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President's Page

In the United States, only three out of one hundred Americans deny the existence of God. Yet, in science, secularism has worked overtime to divorce God from its thinking. The more medicine has been converted from an art to a science, the farther it has strayed from its Source of power, and this is in a country where every branch of government officially and publicly recognizes our dependence, as a nation, on the Creator.

From the *Christopher News Notes* of March come these historical facts. In the Executive branch, every President from Washington to Eisenhower has publicly acknowledged God. Excerpts from some inaugural addresses follow:

Washington: "...in this first official act, my fervent supplication to that Almighty Being who rules over the universe ..."

Jefferson: "...acknowledging and adoring an overruling Providence ..."

Madison: "...in the guardianship and guidance of that Almighty Being whose power regulates the destiny of Nations ..."

Lincoln: "...in the right, as God gives us to see the right ..."

Wilson: "God helping me, I will not fail them."

Hoover: "I ask the help of Almighty God."

Roosevelt: "We humbly ask the blessing of God... May He guide me in the days to come."

Truman: "We believe that all men ... are created in the image of God."

Eisenhower: "... we beseech God's guidance."

In the Judicial, Supreme Court Justice, Robert H. Jackson, stated: "One can hardly respect a system of education which would leave the student wholly ignorant of the currents of religious thought that move the world society." In 1952, Supreme Court Justice, William O. Douglas, said: "We are a religious people whose institutions presuppose a Supreme Being."

In the Legislative branch, a bill enacted by both houses in 1954 added the words "under God" to the pledge of allegiance to the flag. In 1956 Congress proclaimed "In God We Trust" as the national motto of the United States — a guiding principle which Secretary of the Treasury, Salmon P. Chase, had engraved on all coins in 1863.

Since such are the proclamations of our national leadership, it is fitting and proper that a profession of Faith be a formal part of a national convention devoted to the art and science of medicine. Your Federation has introduced the instruments for this profession of Faith. During the annual A.M.A. convention a Memorial Mass is offered for all deceased members; at the same time an exhibit is maintained in the Convention Hall.

Make every effort to do three things when you come to Atlantic City in June.

Attend the Memorial Mass at 5:00 p.m. at St. Nicholas Church, Wednesday, June 10.

Register at Booth #M-26-a, the Federation Exhibit in Convention Hall.

Have delegate representation at the Executive Board meeting, 9:30 a.m. at Hotel Dennis, June 10. Observers are welcome.

Be a "Christopher!" Show a personal and practical responsibility in restoring the love and truth of Christ in the market-place.

WILLIAM J. EGAN, M.D.

HYPNOSIS: A Medico-Moral Evaluation

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Author's Introductory Note: About two years ago at the request of His Eminence, the late Samuel Cardinal Stritch, Archbishop of Chicago, we started an investigation into the subject of hypnosis with the intention of making a medico-moral evaluation. To facilitate our work we drew up a questionnaire and sent it to six leading Catholic psychiatrists: Father William J. Devlin, S.J., of Loyola University, Chicago, Ill.; Doctors Francis J. Braceland of the Institute of Living, Hartford, Conn.; Francis J. Gerty of the University of Illinois, Chicago, Ill.; John J. Madden of Loyola University, Chicago, Ill.; John I. Nurnberger of the University of Indiana, Indianapolis, Ind., and to Edward A. Strecker of the University of Pennsylvania, Philadelphia, Penn. These men mediately or immediately directed us to send the questionnaire also to the following doctors who have been using hypnosis in their clinical practice: Doctors Milton H. Erickson, President of the American Society of Clinical Hypnosis, of Phoenix, Ariz.; Merton M. Gill of Berkeley, Cal.; William S. Kroger of Chicago, Ill.; Lawrence S. Kubie of New York, N.Y.; Harold Rosen, Executive Secretary of the Society for Clinical and Experimental Hypnosis, of Johns Hopkins University, Baltimore, Md., and Lewis R. Wolberg of New York, N.Y. We also sent the questionnaire to Mr. Stanley L. Morel, a hypnotist studying in Chicago, Ill.

Since all thirteen of these men answered the questionnaire in more or less detail, our debt of gratitude to them is very great. Some sent important articles and references to help in the study. In the body of the article where we quote these men without any specific reference we are quoting from their private answers to the questionnaire.

Two other sources that we found especially helpful are the two official reports on hypnosis made by the British Medical Association, published in the *British Medical Journal*, April 23, 1955, and by the American Medical Association, published in the *Journal of the American Medical Association*, Sept. 13, 1958.

I. NATURE OF HYPNOSIS

AT the present time it is impossible to give a philosophical definition of hypnosis. Psychiatrists and other doctors who use hypnosis in their clinical practice know what effects they can produce in a patient under hypnosis. But they readily admit that they do not know precisely what is the nature of hypnosis.

Hypnosis derives its name from the name of the Grecian god of sleep, Hypnos. Both the procedure of inducing the artificial state of the one under hypnosis and the artificial state itself have been

called by various names. The procedure has been called animal magnetism, mesmerism, psychological lobotomy, hypno-anesthesia, medical relaxation, suggestive relaxation, psycho-prophylactic relaxation, and the like. The artificial state itself has been called sleep, trance, hypnotic state, a kind of artificially induced sleep, a state of mental absorption, a concentration of the mind on one idea, a temporary condition of altered attention, a state of exaggerated suggestibility, and the like.

Up to relatively recent times

many have thought that a state of hypnosis could not be produced by natural powers, but only by some preternatural power which they ascribed to the evil spirit. As a result, the word "hypnotism" has been used to signify spiritualistic phenomena founded in superstition or in the working of the evil spirit. But the hypnotic state is not a state induced by so-called "occult" practices, nor is it associated in nature with witch-craft, black magic, spiritualistic seances, or the like. Hypnosis is not fakery or foolishness; it is not merely a sort of game or entertainment. Rather it is a matter for serious scientific investigation. Hypnosis is not a state of sleep, as sleep is ordinarily understood. It seems to be more like the waking state than like ordinary sleep.

Today we know that the induction of an hypnotic state need not transcend the natural powers of man. Hypnosis is founded in relaxation, concentration, and suggestion. By suggestion the hypnotist induces a relaxed subject to concentrate his attention so intensely on one object that he finally becomes aware of that object alone. Then, after the subject is in the hypnotic state, the hypnotist, if he so desires, and with the permission of the subject, widens the field of awareness even to the point where the subject is apparently completely alert to all things. Yet, according to the suggestion of the hypnotist, he is completely unaware of more or less restricted areas of sensation, for example, of sensations of pain in just one particular part of the body. In the

process of induction the subject remains silent and inert. But as Doctors Kubie and Margolin observe so well:

once he is fully hypnotized the subject need not remain silent, inert and apart. If appropriate words from the hypnotist engender corresponding purposes in the subject, he will walk around, converse intelligently, and in general make it evident that his sensori-motor horizons have re-expanded, seemingly to their pre-hypnotic limits.¹

After this brief description of what hypnosis is and what it is not, it will help to clarify our thinking during the rest of this study if we settle on a sort of working definition of hypnosis. The British and American Medical Associations provide us with just such a definition. The British Medical Association's report formulated the definition with which the American Medical Association's report is in agreement. It reads as follows:

[Hypnosis is] a temporary condition of altered attention in the subject which may be induced by another person and in which a variety of phenomena may appear spontaneously or in response to verbal or other stimuli. These phenomena include alterations in consciousness and memory, increased susceptibility to suggestion, and the production in the subject of responses and ideas unfamiliar to him in his usual state of mind. Further, phenomena such as anesthesia, paralysis, and the rigidity of muscles, and vasomotor changes can be produced and removed in the hypnotic state.²

As we would readily conclude, the hypnotic state in the individual case can be more or less superficial or more or less deep. Some

¹Kubie, Lawrence S., M.D., and Margolin, Sydney, M.D., "The Process of Hypnotism and the Nature of the Hypnotic State," *The American Journal of Psychiatry*, Vol. 100, No. 5, March, 1944 (pp. 611-622), p. 618.

²*British Medical Journal*, April 23, 1955.

authors give as many as nine or ten different hypnotic states according to the depth of the state. Others, restricting the number, include the nine or ten within their own number of four or five. Ordinary distinctions are made between what are called "waking suggestion," "waking hypnosis," "superficial state," "somnambulistic state," and the "coma or trance state." Also, depending, on how widely he interprets and applies the term, hypnosis, one doctor will find a state of hypnosis where another will deny its presence. One doctor will maintain, for example, that the method of so-called "natural childbirth" is not a type of hypnosis, whereas another doctor regularly using hypnosis and practicing in the field of obstetrics and gynecology maintains that it is.

There is also wide variation in the techniques of inducing the hypnotic state. Seemingly there is little superiority of one method over another, when each is competently applied. If the hypnotist is confident in his technique, if he is sufficiently persuasive and persistent, and if he knows how to shift his technique in accordance with the changing reactions of his subject, he will probably be rewarded with a maximum of induction successes. All literature on the subject agrees that it is easy to learn how to hypnotize.

Judgments among hypnotists still differ markedly on two points that most intimately touch the field of morals. Some maintain that those in an hypnotic state will refuse to execute commands which in their usual state of mind they

would not do because of moral objections. Others judge that they can induce a person under hypnosis to act contrary to the dictates of his conscience. To these latter the extent to which the hypnotized person will follow the suggestions of the hypnotist seems to depend on the depth of the hypnotic state. There is also definite disagreement about whether it is possible by suggestion to induce an hypnotic state in an unwilling subject.

Another type of hypnosis coming to the fore today is self-hypnosis or auto-hypnosis. This is not the same as auto-suggestion. In auto-suggestion there is no relation, real or fancied, with any other person. In self-hypnosis there is implied a relation between two individuals: the subject and his hypnotist. Certain physicians will hypnotize a particular patient and instill in him a post-hypnotic suggestion that the patient can by performing certain actions hypnotize himself when he wishes.³

From what has been said so far, it is apparent that although hypnosis is being used today as a medical procedure, a great deal of work must yet be done to explore more thoroughly its nature, and to determine more accurately its long-range effects as well as criteria for the selection of patients.

II. MEDICAL USES OF HYPNOSIS

In general, hypnosis today is a recognized aid to medical and psy-

³Rosen, Harold, Ph.D., M.D., "Hypnosis, Mental Hygiene, and the Dentist-Hypnotist," *Journal of Clinical and Experimental Hypnosis*, Vol. V, No. 3, July, 1957 (pp. 101-131), esp. pp. 121-125.

chiatric practice, as an adjunct to other therapeutic techniques. In confirmation of this statement we need only inspect the hospital records which tell of its success in actual use. Courses in medical hypnosis have been offered in some, even though in only a very few, accredited medical schools, for example, in Seton Hall College of Medicine and Dentistry, the Catholic medical school in Newark, New Jersey. Both the American and the British Medical Associations recommend in their reports that courses be established under proper auspices for the training of doctors in the proper medical uses of hypnosis. And they both encourage active participation in high level research by members of the medical and dental professions.

"[Hypnosis]," according to the report of the British Medical Association, "has been of great importance to the growth of modern psychotherapy." The subcommittee which helped draw up the published report was satisfied that: . . . hypnosis is of value and may be the treatment of choice in some cases of so-called psychosomatic disorder and psychoneurosis. It may also be of value for revealing unrecognized motives and conflicts in such conditions. As a method of treatment it has proved its ability to remove symptoms and to alter morbid habits of thought and behavior.⁴

In the long-term rebuilding of a patient's personality, however, most doctors agree that its best practical use lies in effecting a proper rapport between the patient and the doctor.

Its other medical uses are as an analgesic or anesthetic agent.

⁴*British Medical Journal*, April 23, 1955.

Acute pain (such as is found, for example, in migraine headaches), chronic pain (such as is found in terminal cases of cancer), and post-operative pain, all have been alleviated by hypnosis. In addition, there is the obvious advantage that in these cases habit-forming drugs are altogether unnecessary or needed in only modified amounts.

As an anesthetic during surgery hypnosis has been used by itself, that is, without any drugs, and as an adjunct to the use of drugs. By itself, hypnosis has been used frequently enough in dentistry, in painful diagnostic examinations, and in minor surgery (such as tonsilectomy and plastic surgery). When it is used in major surgery, it is usually used as a valuable adjunct to the use of drugs. In such surgery it can help better the patient's outlook, ease his tensions before the operation, and minimize post-operative shock. The quantity of drugs needed is reduced, if not entirely eliminated. Furthermore, in exceptional cases of major surgery when unfavorable reactions to chemical anesthetics have rendered their use practically impossible, hypnosis has been used successfully by itself. Doctor Joseph Tobin, who uses hypnosis as an anesthetic in his work at Alexian Brothers Hospital, Chicago, Illinois, has used it in doing hernia operations and appendectomies, in setting bones, taking care of rectal abscesses and various lacerations, in doing kidney examinations and other work involving the male genital tract.

In the field of obstetrics, the

judgment that in selected cases there is no danger of ill effects to the mother or child is gaining more widespread approval. The doctors who defend the use of hypnosis as an anesthetic in delivery rooms stress the fact that through its use there is assured a marked decrease in the dangers of fetal anoxia. Evidence from various sources agrees that mothers who delivered under hypnosis delivered remarkably pink babies, who cried remarkably soon after delivery, and that the mothers considered their experience a remarkably pleasant one. But the American College of Obstetricians and Gynecologists does not favor the use of hypnosis as a means of relieving the pains of parturition. In the "Report of the Committee on Obstetrical Anesthesia and Analgesia" which was presented to and approved by the Executive Board of the American College of Obstetricians and Gynecologists at its meeting in April, 1958, in Los Angeles, California, it is stated:

We would welcome a really scientific evaluation of the use of hypnosis in obstetrical practice considered from the obstetrician's and the anesthesiologist's standpoints as well as from the patient's point of view. It must be emphasized that as yet we do not know of evidence to suggest that any large segment of the population, without recourse to anesthetic agents in an effort to relieve pain, can undergo the experiences of labor and delivery in a manner satisfactory to themselves, and at the same time accomplish delivery with preservation of as great a measure of maternal health and with as little effect on fetal life as is commonly realized by the usual conduct of labor employing analgesics and the induction of anesthesia for the actual delivery.

We must keep in mind the fact that zealous emphasis of the merits of any single method of conducting labor and delivery

may lead to the neglect of skills that are life-saving when the not too infrequent abnormalities and emergencies arise. We would emphasize that a real danger exists in the development of an enthusiastic faith in the spontaneity and naturalness of parturition, if this state of mind results in the deterioration of the facilities and personnel necessary to accomplish operative delivery promptly and efficiently. When operative delivery is indicated, the almost perfect safety that a highly developed anesthesia-operating team is most likely to assure is an asset that tomorrow's mothers can not afford to lose.

At this time this Committee neither recommends nor condemns the employment of hypnosis as a means of relieving the pains of parturition. We believe, however, that the dangers and advantages inherent in the employment of both general and regional anesthesia are better known and more widely appreciated. It is evident that the majority of obstetricians and anesthesiologists are not able to recognize those individuals with a psychotic tendency for whom hypnosis might have most undesirable consequences. Adaption of this procedure to the needs of any considerable proportion of women during labor and delivery should be the responsibility of, and accomplished at the direction of, competently trained psychiatrists. Their evaluation of this technique should precede any extensive trial of the procedure.⁵

The doctors whom we consulted were not very explicit in suggesting criteria for the selection of patients on whom hypnosis could be safely used. Most of them agreed that if hypnosis was contemplated for purposes of anesthesia alone, then the patient should be emotionally stable, that is, that there should be no clinical evidence of mental disorder. One doctor suggested that a dentist before using hypnosis as an anesthetic should routinely ask his patient whether he is under psychiatric treatment. Another doctor, Doctor Milton H. Erickson, stated that the only criterion

⁵Quoted from a private hectographed copy of the Report.

needed is a positive answer to the question whether the patient is willing and can be hypnotized.

It is also noteworthy that according to an estimate made by Doctors Sol T. DeLee and William S. Kroger only about 10% of carefully selected patients can be hypnotized sufficiently to allow major surgery without the aid of drugs.

Doctor Lewis Wolberg in his study, "Current Practices in Hypnotherapy," (p. 230), gives the following excellent summary of the medical uses of hypnosis:

Employed by a reasonably trained professional, within the context of a structured therapeutic program, with proper awareness of limits of its application and with appropriate timing, hypnosis can make a contribution as an adjunct to any of the manifold branches of psychotherapy whether these be directive, non-directive, supportive, re-educative, or psycho-analytic. Hypnosis also has value as a reassuring and analgesic agent, both as a means of composing apprehensive patients and as a mode of lessening pain. It has been used with effectiveness as a preliminary measure in electric shock therapy, obstetrics, minor surgery, plastic surgery, dentistry, and diagnostic examinations such as bronchoscopy and sigmoidoscopy. The dangers inherent in its use are few or non-existent, if it is skillfully employed by a responsible operator.⁶

III. DANGERS

That there are dangers from the use of hypnosis cannot be denied. The British Medical Association in their report summed up the matter this way:

The dangers of hypnotism have been exaggerated in some quarters. The Subcommittee is convinced, however, that they do exist, especially when it is used without proper consideration on persons

predisposed, constitutionally or by the effects of disease, to severe psychoneurotic reactions or anti-social behavior. The commission of crimes involving even danger to life is not entirely to be ruled out.⁷

Such predisposed persons are judged by some doctors to be those who have latent, that is, partially or fully concealed, paranoid tendencies. But many doctors believe that paranoid patients would resist the use of hypnosis.

Father William J. Devlin, S.J., M.D., says that it is "very questionable whether hypnosis should be used in the case of a schizophrenic personality. I did not say schizophrenic psychosis." Doctor John I. Nurnberger adds that "the primary danger for a psychiatric patient is the coercive achievement of a seemingly desired goal for which the patient is not otherwise prepared." Another doctor, who wishes to remain anonymous, mentions this danger that "in precarious adjustments more obvious states of psychiatric disorder may be precipitated."

Other dangers that might be listed are: undue attachment to the hypnotist, failure of the hypnotist to cancel suggestions not specifically meant for retention which could have unintended adverse post-hypnotic effects, removal of symptoms without discovery of the cause, masking of possible symptoms, fears of the patient due to lack of knowledge of what happened under hypnosis and consequent distrust of the doctor.

Doctor Harold Rosen of the Johns Hopkins University School

⁶"Current Practices in Hypnotherapy," *Progress in Psychotherapy*, 1956, Grune & Stratton, Inc., (pp. 217-233), p. 230.

⁷*British Medical Journal*, April 23, 1955.

of Medicine cautions against the use of self-hypnosis. "There is little," he says, "in the whole field of psychodynamics with so great a potential for harm." By way of explanation he continues:

The desire for self-hypnosis, whatever the rationalization advanced by its practitioner, when investigated frequently turns out to be a desire to further fantasy formation, to facilitate sinking deeper and deeper into a dream world of one's own. . . . Some dentists and obstetricians are now suggesting to their hypnotized patients that, whenever they have headaches, they can hypnotize themselves and thereby be rid of them. We have seen three such dental patients. Self-hypnosis for them had dangerous sequela. With a fourth, however, it may or may not have constituted a problem. But with every dentist and with every physician who himself practiced self-hypnosis and whom we ultimately examined psychiatrically—there have been some 10 or 12 patients in this category—it was exceedingly dangerous. All were compounding trouble for themselves.⁸

Sometimes, too, recordings are used to hypnotize others. This is dangerous because there is no one present to observe reactions. If a doctor were present and saw unfavorable reactions, he could stop the hypnotic process. For instance, a woman physician was among a group listening to recordings designed to hypnotize them. As a result, she was almost in a panic some twelve hours later and requested emergency psychiatric help.⁹

Before we conclude this treatment of dangers we should say something about the dangers of hypnosis used specifically for entertainment purposes. While there are exceptions, in almost all cases

the high pressure and speed required in stage work leaves much to chance. The entertainer-hypnotist does not know the person he is hypnotizing. He has not had previous conferences and background material, so that he would know what not to ask the person to do. Even if he had such information, he is not trained in psychological behavior; he does not know enough about human emotions and about the emotional bases of human behavior to avoid all danger. The result is that he could run into psychological reactions with which he is not prepared to cope. The person hypnotized can have severe emotional upsets due to the embarrassment he experiences after hypnosis. To see others laughing at him and to be unaware of what really happened can have a permanent effect upon the subject. One doctor reports that he saw such cases. If the hypnotist actually induces an hypnotic state before an audience, there is some danger that some members of the audience also will be hypnotized. This is dangerous because the hypnotist might not even think of the need to bring these individuals out of their hypnotic state.

IV. MORAL EVALUATION

In the nineteenth century, from 1840 to 1899, various authoritative directives were given by Catholic ecclesiastical authorities in Rome. Two answers each were given by the Holy Office and by the Sacred Congregation of the Inquisition, and a circular letter was sent by the latter Congregation to all

⁸Rosen, Harold, Ph.D., M.D., loc.cit., pp. 121, 122.

⁹Rosen, Harold, Ph.D., M.D., loc.cit., p. 124.

Bishops. These directives condemned the abuse but not the legitimate use of hypnosis. To illustrate what was contained substantially in all the directives we cite in detail the following question and answer. In 1840 the Holy Office was asked:

Should magnetism, considered in general and in itself, be judged lawful or not?

On June 23, 1840, the Holy Office replied:

Where all error, divination, and explicit and implicit calling on the devil is absent, the mere act of employing physical means otherwise lawful is not forbidden, provided they do not tend to any unlawful or sinful purpose. But the application of principles and merely physical means to explain physically things and effects which are really supernatural is nothing but unlawful and heretical deception.¹⁰

It is clear, therefore, that all use of hypnosis to further superstitious practices is morally sinful.

Within the past few years Pope Pius XII made two statements about hypnosis, the first in his address to an audience for gynecologists, January 8, 1956, the second to members of a symposium on anesthesiology, February 24, 1957. In these statements the Pope showed, as Father Kelly observes, "that he considered this as primarily a medical question and that the judgment of its morality would ultimately be based on sound medical opinion."¹¹ Here is the pertinent part of the second address: But consciousness can also be reduced by artificial means. It makes no difference

¹⁰Quoted by Ballerini, Antonius, S.J.,—Palmieri, Dominicus, S.J., *Opus Theologicum Morale in Busembaum Medullam*, Prati, 1889-1892, Vol. II, n.366.

¹¹Kelly, Gerald, S.J., *Medico-Moral Problems*, The Catholic Hospital Association of the United States and Canada, St. Louis, Mo., 1958, Chapter 32, "Hypnosis as Anesthesia," p. 289.

from the moral standpoint whether this result is obtained by the administration of drugs or by hypnosis, which can be called a psychic analgesic. But hypnosis, even considered exclusively in itself, is subject to certain rules. . . . In the matter which engages Us at present, there is question of hypnosis practiced by the doctor to serve a clinical purpose, while he observes the precautions which science and medical ethics demand from the doctor as much as from the patient who submits to it. The moral judgment which We are going to state on the suppression of consciousness applies to this specific use of hypnosis. But We do not wish what We say of hypnosis in the service of medicine to be extended to hypnosis in general without qualification. In fact, hypnosis, insofar as it is an object of scientific research, cannot be studied by any casual individual, but only by a serious scientist, and within the moral limits valid for all scientific activity. It is not the affair of some group of laymen or ecclesiastics, who might dabble in it as an interesting activity for the sake of mere experience, or even as a simple hobby.¹²

The papal statements seem reducible to the following succinct principle: When hypnosis is medically indicated, it is morally unobjectionable, that is, if employed by a reasonably trained professional.

In making our final conclusion about the morality of the use of hypnosis we should consider five requirements:

1) The doctor practicing hypnosis must be a competent and conscientious practitioner. Since at the present time there is no professionally recognized set of standards for judging the competence of the hypnotist, hospitals have had to set up their own standards. Schools and groups which conduct courses in the nature of hypnosis and in the tech-

¹²Translation from the *Catholic Mind* (May-June, 1957), pp. 271, 272.

niques of induction grant what amounts to a certificate of attendance but commonly grant no certificate of competence.¹³ In one hospital the staff members sit in judgment on the competence of the doctor wishing to use hypnosis, in another the head of the individual department (for example, of the obstetric department) judges that the doctor may or may not use hypnosis. In making this judgment there is special need to make sure that the hypnotist is a doctor of high professional integrity, of balanced judgment, and of good moral character. Where prudence demands, there should be at least a third person present to protect the interests both of the patient and of the doctor, especially when the patient is a woman. Pertinent to this first requirement are the words of the report made by the American Medical Association, in introduction of which Richard J. Plunkett, M.D., secretary, asserts:

Preliminary investigation by the Council revealed that centers for training, under proper auspices, were sharply lacking. It was also noted that many courses in hypnosis were being offered to physicians and dentists by groups who, in the Council's opinion, were not properly accredited by any professional school or university. Likewise, courses were being offered to physicians and dentists on the basis of a 5-lesson or 10-lesson course in hypnosis, offered solely as correspondence courses. . . . In substance, the Council's report indicates that there are definite and proper uses of hypnosis in medical and dental practice *in the hands of those who are properly trained*.

¹³An exception to this general statement is found in the training program of The American Society of Psychosomatic Dentistry and Medicine which leads to a certificate of competence according to a mimeographed copy of the Society's constitution and by-laws issued in 1958.

(The report itself adds:)

It has already been emphasized in this report that a background of psychodynamic psychology and psychiatry is essential in order to understand the phenomena of hypnosis. It is equally important to insist on the fact that the utilization of hypnotic techniques for therapeutic purposes should be restricted to those *individuals who are qualified by background and training* to fulfill all the necessary criteria that are required for a complete diagnosis of the illness which is to be treated. Hypnosis should be *used on a highly selective basis* by such individuals and should never become a single technique used under all circumstances by a therapist. No physician or dentist should utilize hypnosis for purposes that are not related to his particular specialty and that are *beyond the range of his ordinary competence*. . . . General practitioners, medical specialists, and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. . . . Teaching related to hypnosis should be under responsible medical or dental direction, and integrated teaching programs should include not only the techniques of induction but also the indications and limitations for its use within the specific area involved. Instruction limited to induction techniques alone should be discouraged. Certain aspects of hypnosis still remain unknown and controversial, as is true in many other areas of medicine and the psychological sciences. Therefore, active participation in high-level research by members of the medical and dental professions is to be encouraged.¹⁴

N.B. Emphases in above added by author.

2) A proportionate cause is required, because we are not permitted without a compensating reason to give up our dominion over the rational faculties of understanding and will. When, however, a competent and conscientious physician concludes that hypnosis is medically indicated, we may accept his assurance that it is for the benefit and general health of his patient. But enter-

¹⁴*Journal of the American Medical Association*, Sept. 13, 1958, pp. 186-189.

tainment value is not justification for the use of hypnosis, any more than it would be for drunkenness or any other temporary deprivation of the use of reason. For this reason and because of the dangers involved we agree with the condemnation in the American Medical Association's report that "the use of hypnosis for entertainment purposes is vigorously condemned." Our judgment is that it is objectively sinful to use hypnosis just for purposes of entertainment. The matter itself is serious, although it does admit of parvity of matter. In an individual case, therefore, the sin could be venial.

3) The consent of the patient must be procured, because no one has the right to deprive another against his wishes of the full use of his faculties. It is not necessary, however, always to obtain the explicit consent of the patient.

4) "There should be no unjustifiable risk of harm for the patient."¹⁵ This requirement is always necessary for the lawful use

of drugs, surgery, or other medical procedure.

5) And finally, "professional secrecy must be rigidly observed concerning the information gleaned in the course of the treatment" under hypnosis.¹⁵

Our final capsule medico-moral conclusion, therefore, is: When hypnosis is medically indicated, it is morally unobjectionable, that is, if employed by a reasonably trained professional.¹⁶

¹⁵Requirements 4) and 5) are taken from Father Gerald Kelly's book, *Medico-Moral Problems*, quoted above, Chapter 31, "Narcoanalysis and Hypnoanalysis," pp. 284, 285.

¹⁶This conclusion and these five requirements, in our opinion, are in accord with the *Ethical and Religious Directives for Catholic Hospitals*, The Catholic Hospital Association of the United States and Canada, Second Edition, 1955, and in particular with No. 45 which reads as follows: "The use of narcosis or hypnosis for the cure of mental illness is permissible with the consent at least reasonably presumed of the patient, provided due precautions are taken to protect the patient and the hospital from harmful effects, and provided the patient's right to secrecy is duly safeguarded."

Young Doctors! The Smaller Communities Need You!

JAMES E. BOWES, M.D.

The Editor's Comment: The Catholic Hospital Association receives many requests for help to augment the medical staffs of member hospitals. Interest in this vital need on the part of Dr. James E. Bowes, a young Catholic obstetrician-gynecologist engaged in practice in Salt Lake City, Utah, resulted in a most intensive survey of the field. THE LINACRE QUARTERLY publishes here the results of Dr. Bowes' efforts to conduct the study after contacting the 850 Catholic hospitals in the United States. Needs are grouped according to general practice and the specialties.

In the April 1957 issue of *Medical Economics* an article appeared, entitled "How I Found the Ideal Place to Practice" (pp. 158-165, 323-326). It was an account of Dr. Bowes' search for the best possible location for his needs. The study brought to light the fact that every year an estimated 17,000 doctors change locations (cf. *Medical Economics*, November, 1953). In appraising cities and climate and population to help make the decision which was vital not only to himself but also to his growing family, Dr. Bowes finally chose Salt Lake City as ideal for his purposes. It is his hope that his thorough consideration of many areas before finally deciding, may, with the publishing of the survey results, be incentive for other physicians to do likewise and give thought to areas that would welcome energetic Catholic doctors to practice medicine.

The Catholic Hospital Association expresses deep gratitude to Dr. Bowes for the many hours he must have taken from his work for the project. Hopeful, too, that among our physician readers there may be some who would be interested in establishing practice and assisting on the staffs of Catholic hospitals in the locations listed, we urge further inquiries. Kindly address:

Reverend John J. Flanagan, S.J.
Executive Director
The Catholic Hospital Association
1438 So. Grand Blvd.
St. Louis 4, Missouri

Names of the hospitals and other details will be furnished.

* * * *

Each year more than 6,000 young men and women graduate from medical schools and as many finish residency programs. Both groups have important decisions to make: Shall I become a general practitioner or shall I specialize? Where should I locate?

Recently a survey was conducted of the physician needs in the 850 Catholic hospitals throughout America. Only towns of less than one million population were considered. Some 493 hospitals, representing 466 communities returned the questionnaire. We have gathered the following information from them to pass on to those doctors who will either establish an office or who desire to relocate.

The chief aim of the inquiry was to discover the greatest needs the hospitals had in the various specialties. The hospital administrators were also asked the number of specialists already on their staffs and what proportion were Catholic. The responses were enlightening.

There were 66 communities needing obstetricians-gynecologists; 60 require surgeons; 57 psychiatrists; 47 internists; 44 pediatricians; 30 generalists; 27 urolo-

gists; 14 orthopedists; and 18 EENT specialists. Trained men were needed in the sub-specialties of eye, neuro-surgery, neurology, pathology, anesthesiology and dermatology. Various cities had special need for a plastic surgeon, proctologist, chest surgeon or qualified men in the newer fields of rehabilitation, clinical research, and physical medicine.

A geographic distribution of hospitals found almost 50% located in the twelve north central states. This same area requested 64% of the surgeons needed in this survey. More than one-half of the psychiatrists are needed in the northeastern quarter of the country. Obstetricians are in great demand in the west north central states, as are pediatricians, internists, urologists and general practitioners. The west north central states have the greatest demand for specialists, while they are in least demand in the east south central, south Atlantic and New England states. These areas prefer general practitioners.

Choosing a location for individual requirements precludes following a set pattern. But the doctor's primary objective should be to find the city where he and his family want to live for the rest of their lives. It should offer educational, cultural and recreational advantages. Look into them well, in that order.

The young specialist just out of residency need not fear the thought of opening an office. He should not despair at the idea of moving away from the crowded million population area. And the young medical graduate who seeks general practice will find an open field and a fast growing business. The Catholic intern considering a speciality might refer to the following lists to guide him in his choice. Two of the three greatest specialty needs touch the medico-moral field. Psychiatry and obstetrics-gynecology are excellent fields for young Catholic doctors who have the courage to use their medical talents in Catholic Action.

OBSTETRICS — GYNECOLOGY

Alabama, Mobile
Montgomery
Arkansas, Morrilton
California, Bakersfield
Colorado, Durango
Illinois, Highland
Rockford
East Chicago
Indiana, Gary
Hammond
Iowa, Burlington
Iowa City
Sioux City
Kentucky, Louisville
Louisiana, Thibodaux
Maine, Waterville
Minnesota, Little Falls
Missouri, Boonville
Jefferson City
Monett
Montana, Butte
Helena
New Jersey, Patterson
North Dakota, Grand Forks
Ohio, Dayton
Oklahoma, Oklahoma City
Oregon, Portland
Roseburg
Pennsylvania, Johnstown
South Dakota, Mitchell
Sioux Falls
Tennessee, Knoxville
Texas, Liberty
Utah, Salt Lake City
Washington, Aberdeen
Pasco
Wisconsin, Oshkosh
Racine

OBSTETRICS

California, Inglewood
Colorado, Pueblo
Sterling
Florida, Pensacola
Idaho, Cottonwood
Nampa
Indiana, Evansville
Fort Wayne
Terre Haute
Iowa, Carroll
Des Moines
Fort Dodge
Mason City
Waverly
Kansas, Leavenworth
Manhattan
Louisiana, Opelousas
Michigan, Hancock
Mississippi, Vicksburg

Missouri, Washington
Montana, Anaconda
Nebraska, Atkinson
New York, Utica
Ohio, Kent
Steubenville
Oklahoma, Ponca City
Texas, San Antonio

GYNECOLOGY

Virginia, Norton

SURGERY

Alabama, Ensley
Arkansas, Texarkana
Colorado, Cheyenne Wells
Florida, Miami Beach
Georgia, Athens
Illinois, Centralia
Mt. Vernon
Murphysboro
Indiana, Batesville
Garrett
Iowa, Algona
LeMars
Kansas, Fort Scott
Manhattan
Wichita
Louisiana, Lake Providence
Opelousas
Tallulah
Maine, Eagle Lake
Michigan, Hancock
Tawas City
Minnesota, Alexandria
Graceville
Mankato
Moorhead
Parkers Prairie
Perham
Red Lake Falls
Montana, Lewiston
Polson
St. Ignatius
Washington
Nebraska, Atkinson
Columbus
Lynch
O'Neill
West Point
New York, Binghamton
North Dakota, Cando
Drayton
Hankinson
Harvey
Linton
Ohio, Steubenville
South Carolina, Dillon
York
South Dakota, Aberdeen
Deadwood
Hot Springs

Texas, Abilene
 Jourdanton
 Mineral Wells
 Slaton
 Wellington
 Washington, Tonasket
 Wisconsin, Antigo
 Baraboo
 Columbus
 West Bend

PSYCHIATRY

California, Fullerton
 Long Beach
 Lynwood
 Santa Rosa
 Colorado, Pueblo
 Connecticut, New Haven
 Georgia, Columbus
 Illinois, Chicago Heights
 DeKalb
 Joliet
 Rock Island
 Indiana, Dyer
 Fort Wayne
 Iowa, Waterloo
 Kentucky, Louisville
 Louisiana, Lake Charles
 Massachusetts, Lowell
 Pittsfield
 Springfield
 Michigan, Bay City
 Dearborn
 Hamtramck
 Menominee
 Minnesota, Duluth
 Mankato
 Mississippi, Jackson
 Missouri, St. Joseph
 Montana, Billings
 New Jersey, Passaic
 Trenton
 New York, Buffalo
 Elmira
 Harrison
 Hornell
 Niagara Falls
 Olean
 Watertown
 North Carolina, Charlotte
 North Dakota, Bismarck
 Grand Forks
 Minot
 Ohio, Lima
 Youngstown
 Oklahoma, Enid
 Ponca City
 Oregon, Medford
 South Dakota, Tyndall
 Texas, Austin
 Denison
 Houston
 Port Arthur

Vermont, Winooski
 Washington, Chehalis
 Yakima
 West Virginia, Parkersburg
 Wisconsin, Milwaukee
 Racine

INTERNAL MEDICINE

Arkansas, Little Rock
 California, Eureka
 Long Beach
 Florida, Miami Beach
 West Palm Beach
 Illinois, Cairo
 Murphysboro
 Indiana, New Albany
 Iowa, Centerville
 Dubuque
 New Hampton
 Kansas, Independence
 Wichita
 Kentucky, Lynch
 Massachusetts, Gloucester
 Michigan, Grand Rapids
 Mt. Clemens
 Minnesota, Breckenridge
 Graceville
 Little Falls
 Moorhead
 Missouri, Kansas City
 St. Charles
 Washington
 New Hampshire, Manchester
 Nebraska, Lincoln
 Loup City
 Neligh
 North Platte
 New Jersey, New Brunswick
 Newark
 New York, Rochester
 Woodhaven
 North Carolina, Knoll
 North Dakota, Devils Lake
 Dickinson
 Ohio, Steubenville
 Youngstown
 Oregon, Astoria
 Medford
 Pennsylvania, Meadville
 New Castle
 South Dakota, Gregory
 Mitchell
 Parkston
 Texas, Brownsville
 Washington, Seattle

PEDIATRICS

Alaska, Anchorage
 Arizona, Tucson
 California, Apple Valley
 Idaho, Pocatello
 Illinois, Cairo
 LaSalle

Indiana, Garrett
Iowa, Burlington
 Carroll
 Des Moines
 Fort Madison
 Mason City
Kansas, Concordia
 Hays
 Wichita
Kentucky, Bardstown
Louisiana, Houma
Maine, Fort Kent
Massachusetts, Lowell
Michigan, Grand Rapids
Minnesota, Breckenridge
 Hastings
 Little Falls
 St. Cloud
Missouri, Jefferson City
 St. Charles
Montana, Anaconda
New Mexico, Carlsbad
 Las Vegas
Nebraska, Alliance
New Jersey, Trenton
North Dakota, Minot
 Valley City
Ohio, Kent
 Steubenville
 Youngstown
Oregon, Portland
South Dakota, Aberdeen
 Huron
 Mitchell
Texas, Brownsville
 Paris
Wisconsin, Baraboo
 Port Washington

GENERAL PRACTICE

California, Hanford
Colorado, Lamar
 Leadville
Illinois, Granite City
 Red Bud
 Rockford
 Rock Island
Iowa, Burlington
Kansas, Fredonia
 Marion
Kentucky, London
 Lynch
Maine, Eagle Lake
Maryland, Cumberland
Michigan, Wakefield
Minnesota, Crosby
 New Prague
 Snuk Centre
Missouri, Jefferson City
 Maryville
 Mountain View
Montana, Havre
New Mexico, Carlsbad

Nebraska, Nebraska City
 West Point
North Dakota, Bottineau
 Richardton
Pennsylvania, Meadville
South Dakota, Gettysburg
 Martin
 Pierre
Texas, Brownsville
 Jourdanton
 Yorktown
Utah, Salt Lake City
Washington, Port Townsend
Wisconsin, New London
 Tomahawk
 Columbus

UROLOGY

Colorado, Sterling
Idaho, Boise
Illinois, Chicago Heights
 Pana
Indiana, Gary
Iowa, Burlington
 Estherville
 Fort Madison
Louisiana, Houma
 Opelousas
Michigan, Marquette
 Monroe
Minnesota, New Ulm
Missouri, Ironton
Nebraska, Alliance
New Jersey, Passaic
North Dakota, Bismarck
 Grand Forks
Oklahoma, Enid
Oregon, Coos Bay
Pennsylvania, Johnstown
South Dakota, Yankton
Virginia, Norton
West Virginia, Morgantown
Wisconsin, Port Washington
 Wausau

NEURO-SURGERY

Colorado, Colorado Springs
Indiana, Evansville
Maine, Portland
Massachusetts, Springfield
Missouri, Cape Girardeau
New York, Portsmouth
 Syracuse

NEUROLOGY

California, Fullerton
Idaho, Boise
Montana, Helena
New York, Albana
ORTHOPEDICS
Colorado, Sterling
Georgia, Atlanta

Idaho, Nampa
 Illinois, Chicago Heights
 De Kalb
 Indiana, Gary
 Iowa, Centerville
 Kentucky, London
 Maine, Lewiston
 New Mexico, Santa Fe
 New York, Olean
 Oregon, Astoria
 West Virginia, Morgantown

EYE — EAR — NOSE — THROAT

Indiana, Jasper
 Iowa, Centerville
 Estherville
 Louisiana, Houma
 Monroe
 Massachusetts, Montague City
 Minnesota, Park Rapids
 North Carolina, New Bern
 Ohio, Lima
 Tiffin
 Wisconsin, Merrill

EAR, NOSE AND THROAT

Florida, Jacksonville
 Illinois, Quincy
 Kansas, Kansas City
 New York, Rockville Centre
 Ohio, Sandusky
 Wisconsin, La Crosse
 South Dakota, Sioux Falls

EYE

Indiana, Jasper
 Missouri, Jefferson City
 New Mexico, Santa Fe
 West Virginia, Huntington

PATHOLOGY

Kansas, Hays
 Maine, Waterville
 North Dakota, Grand Forks
 Ohio, Dayton
 Texas, Denison

DERMATOLOGY

Michigan, Grand Rapids
 Ohio, Portsmouth

CHEST SURGERY

West Virginia, Clarksburg

PLASTIC SURGERY

California, Fullerton

PROCTOLOGY

New York, Albany

ANESTHESIOLOGY

Iowa, Algona
 Kentucky, Covington
 London
 Missouri, Cape Girardeau
 Ohio, Tiffin

PHYSICAL MEDICINE

Kentucky, Lexington

REHABILITATION

Ohio, Dayton

CLINICAL RESEARCH

Indiana, Logansport



Christian Morality and The Space Age

JAMES V. MCGLYNN, S.J.

I suppose that if we were to look for the dominant characteristic of our age, we would say that we are living in an age of rapid change. Comparing our era with what many Catholics like to call the Golden Age of the 13th century, we find that whereas St. Thomas had essentially the same picture of the physical world as Aristotle had seventeen hundred years before him, most of us have had to absorb radical changes of outlook within our own lifetime. Perhaps even the majority of us can remember when relativity was a brand new concept and quantum mechanics had not been developed. Or to take your own field of medicine, I for one can remember when sulfa first appeared; and I can remember the hopeless feeling we had when a cousin of mine was down with tuberculosis before the discovery of any of today's wonder drugs. No doubt many of you have had to do much more than the generation before you to catch up on medical developments since you received your degree and hung up your shingle.

Our world has changed and is changing with almost startling rapidity. Who can say what tomorrow's discoveries will be? Just last week we had a new breakthrough in the use of computers. A new mechanical brain has been developed to handle the program-

ming of data which up to now has been the big bottle-neck in using computers. For instance, last year a man from Burroughs told me that the big computer, which is their answer to Univac, was all set to handle a complicated problem involved in wing design but no one was able to program the data for the machine. The new brain developed at MIT will be able to do this for us. It will open new vistas for automation. Who is to say that we will not have similar advances in other fields?

In the face of this swiftly changing outlook of our world it would be easy for man to become light-headed. What are we to think as we see the world being remade around us? Man is more and more becoming the master of nature and might be tempted to set himself up as the ruler of the universe. He might want to declare that the world is made for him and he is its center. This is a possibility and some people have succumbed to the temptation to make the universe anthropocentric.

But in our age no honest thinker can hold this position very long. For while man is learning more and more about nature and finding new ways to master it, his horizons have been rapidly widening. The little universe of Aris-

totle and St. Thomas has burgeoned out into the almost boundless universe of today's astronomers and astrophysicists. Scientists like Harlow Shapley, of the Harvard Observatory, tell us that in the universe the chances for organic life on other solar systems is perhaps one in a million million. And yet even with such tremendous odds there are probably a minimum of one hundred million planetary systems with suitable conditions for the presence of organic life. That is, there are at least one hundred million possible homes for other rational beings. Hence, far from being unique, man might be one of a hundred million species of rational beings and might well be one of the least intelligent of these people.

Meditating on this sobering thought, the man of our world might become extremely humble. Now instead of being created "a little less than the angels," he might be just another rational being on one of the less significant planets in one of the least important solar systems in just another galaxy. Many of today's materialists have panicked at this thought. Rejecting any idea of God and rejecting the traditional theological orientation which put man at the center of the universe as the apex of God's creation, they now have found that instead of hitching their wagon to the evolutionistic star of human achievement, they had tied their hopes to a trivial little meteor which is destined to burn out almost as soon as it begins to glow. The

disillusionment has led some to despair and others to a sense of futility. For both types the byword is "Don't hope for too much."

What about the Christian? The world is no less changing for him than for any other human being. What sort of adjustment, therefore, must the Christian moralist make as he sees the old boundaries fade away and the old landmarks disappear? Must his idea of man and his place in the universe be revised? Must he also learn not to hope for too much?

Before we try to answer this question, let us consider just what it is that we are being asked to adjust to. What is this new universe opening before our eyes and how does man sink into insignificance before it? That the universe is immense beyond the wildest dreams of earlier ages is certainly true. That the conditions necessary for organic life, and hence for rational beings like ourselves, can be found on other planets in solar systems would seem to be not only possible but even probable. If we take what Professor Shapley considers to be a conservative estimate, there are one hundred million possible planetary systems in which organic life could be found. Offhand, it would seem highly improbable that not one of these one hundred million systems would have intelligent beings. Fr. O'Connell of the Vatican Observatory, as quoted in the Catholic press a few weeks ago, also thinks it "brash and even presumptuous" to deny that other

intelligent material beings exist in the universe.

Actually, I suppose, we have to admit that we are in very much the same position as our European ancestors were in 1492. They did not know whether Columbus was going to fall off the edge of the world or find some new race of beings, possibly more intelligent than themselves, possibly, too, untouched by original sin. Would it be a race they could live with or one which might enslave or destroy them?

They simply did not know. Perhaps all of this was not very well formulated in their minds, just as it is not very well formulated in most of ours today. But the gnawing fear and uncertainty is there. We really don't know just what to expect.

There are three basic possibilities. First, we may find planets suitable for human life but on which there are no rational beings so that we would be free to colonize them without infringing in any other rational being's domain. Secondly, we may find planets with intelligent beings already living there, but beings who are less intelligent than we are and with a less advanced civilization and culture than ours. Thirdly, and this is the fearful prospect, we may find planets which are inhabited by rational beings who are much more intelligent than we and who are so far advanced technically and scientifically that they could easily enslave us or exterminate us as the European colonists have practically exterminated the Indian population of America.

Only the future can tell us which of these will actually be the case. This being so, we are in no position to affirm with certainty that man is or is not unique in the universe. The chances are that he is not and that sooner or later we will have to adapt our thinking to a new perspective which must include other thinking animals on other planets. The Christian's thinking will be complicated by the consideration of whether these beings have contracted original sin and been redeemed or are living in a purely natural state or, finally, in a supernatural economy different from ours, a life of grace without original sin. Theologians can entertain themselves working out the various possible relationships between the children of Adam and these creatures of outer space. Such speculation is interesting but would take us too far afield.

Now to get back to our problem, does this expanding horizon bring any essential change in the outlook of the Christian moralist? Obviously, a naturalistic morality, which determines right and wrong solely in terms of man and the rest of the visible universe, is going to have to change its ideas radically when the place of man in this universe is radically changed. Does this hold also for the Christian moralist? Anyone who understands the basis of Christian morality will know that it is not founded primarily on man's relationship to the rest of creation but on his relationship to God. And this is not essentially modified by the presence or absence of other

intelligent beings. Whether there are two or two million billion intelligent creatures in the universe, our condition before God is *essentially* the same.

I say *essentially* because we are related to God as individual human persons. It is true, of course, that man is a social animal and has various obligations to his fellow men, as you yourselves experience, perhaps acutely at times, in the practice of medicine. But morality is not a group enterprise. Someone else may pay our debts and someone else may be able to take care of our families, someone else may even, in the rare case where it is necessary, patch up one of your patients after you have given the wrong treatment, or straighten out a student to whom I have given the wrong answer. Other people can do all of this but only we alone can fulfill our moral obligations. When it comes to right and wrong, each of us stands alone before God. In our innermost self, when we are alone with our conscience, we know that we are really not alone. God is there with us. And our moral obligations result from this personal relationship which we individually have to God.

Consequently, Christian morality will be fundamentally the same whether there is one human race or a million. The difference will be that if and when we discover other rational beings, we will have to remember that they, too, are intelligent beings, persons with souls, people who have the same relationship to God which we have. We must therefore treat

them as human persons, children of God, whose rights as persons we must respect. Thus if they are less developed intellectually and culturally than we, we will have no right to exterminate them. The spiritual value of a human person remains whether he be a brilliant scientist or a poor mongoloid child, or, now we must add, a creature from another world. This will hold equally for all space people, no matter what their level of intelligence and culture. We must accept them as children of God and work for peaceful coexistence in justice and in charity.

This is a problem of the space age which is purely theoretical at the present time but one which may become practical even in our life time. I would like now to take up a more practical problem, which may have repercussions in your lives as physicians and surgeons. The problem is: What is the morality of sending men into outer space?

Not long ago the air force announced that it had picked two hundred men from whom the first U.S. space explorer will be chosen. These were screened down to thirty-six; finally to twelve from whom the actual space traveler will be picked. Recently, too, it has been announced that the contract has been let for the capsule in which the space man will travel. Delivery is expected in two or three years. From all this it should be obvious that certain of your colleagues are right now faced with the question of the morality of sending men into space. For their experiments and their

decision will be decisive. If they say no, the military will hardly dare send a man riding a rocket into space. How can these doctors decide?

To begin with, there is no problem about space travel as such. We have got beyond the foolish fears which some men had about the immorality of new-fangled ideas. You may have heard the argument. When bathing became popular fifty or sixty years ago, some diehards thought it unnatural. People with the same mentality predicted God's judgment on the world for man's use of aircraft, saying that if God had wanted us to fly, he would have given us wings. It does not take much philosophy to answer this. Plato saw it 400 years before Our Lord's coming. And St. Thomas in his dry logical way points out that whereas God gave lower animals special protective coatings—fur, feathers, shells, etc. and natural instincts; in place of these He gave man intelligence to clothe himself, to protect himself and to grow in knowledge and culture. The exploration of space is one use of this intelligence and so in itself is perfectly legitimate.

If there is a moral problem in space travel it arises because in sending men out into space we are risking their lives. Consequently, being rocketed out into space, is from the moral point of view just a more spectacular form of the hazardous enterprise which man has undertaken ever since the first man climbed a tree to get the juicy pear on the topmost branch or

stalked a boar to bring it home for the family dinner.

The moral principles are the same. Our old friend, the principle of the double effect, which has done yeoman service for the moral theologians for centuries, applies here as it applies to other cases of risking one's life. The moralist tells us that one can expose himself to the danger of death if there is a proportionately grave reason, if death is not intended, and if death (should it occur) would follow from a good or at least an indifferent action. You are well aware of the use of this principle regarding a doctor who is working with contagious diseases. An heroic member of your profession in a less antiseptic civilization than ours might expose himself to almost certain death to minister to the plague-stricken. Or a demolition team may flirt with death to defuse a bomb which threatens some community. At the other extreme the lion tamer, the high wire artist, and the movie stunt man can engage in their dangerous professions, provided the normal safeguards are taken. In all of these cases men are risking their lives and they are allowed to do so because there is sufficient reason for them to run the risk and because death, should it come, is not intended, nor the result of some evil action.

To apply this to space travel, the first thing we must determine is the risk involved. If we send a man out into space, are we sending him to certain death? If it were, no Christian moralist could permit it under normal circum-

stances. And as Catholic Americans we can be proud that our government has never considered such suicide flights. Instead we have begun an extensive program to evaluate the dangers which will be met in space and to discover ways of protecting the pilots who will explore space. The important field of space medicine is engaging some of our best young doctors precisely because our government accepts the basic Christian concept of the value of human life.

But if we cannot in conscience send these explorers to certain death, what must their chances be before we can morally authorize such space explorations? The general rule is that the greater the danger, the more serious must be the reason for performing the action. There is no mathematical proportion possible here. We must try to judge prudently and honestly. In the case of sending a man out into space we should have reasonable assurance that we can bring him back safely. Of course there is always the chance of something going wrong, but given the value of such exploration to national prestige and national defense, we can take this chance. It would be wrong to send someone off into space without taking reasonable precautions—for instance

to send a man up in a rocket before we have sufficient knowledge of radiation hazards, re-entry problems, etc. Our space agencies seem to be prudently cautious in this matter, too, for they are carefully studying the reports from each of our satellite launchings to make it as safe as possible for our space men. The Christian moralists can only applaud this vigilance. As long as it continues we can foresee no conflict between Christian morality and sending American explorers into space. The enterprise is laudable, the means used are not evil, and the risk being run is proportionate to the good result which is sought and desired.

Just a word in conclusion. The Christian need not fear the space age. In his morality he has all the principles needed to guide him through these new experiences. The solid rock of divine truth on which our morality rests will never weaken and never change. We can look into the space age with confidence and hope. New problems will arise but Christian morality will be well able to solve them.

Father McGlynn of the Philosophy Department of the University of Detroit gave this address to the Detroit Catholic Physicians' Guild at their annual Communion breakfast in March.

The Impediment of Impotency and The Condition of Male Impotence

A Canonical-Medical Study

REV. PAUL V. HARRINGTON, J.C.L. AND CHARLES J. E. KICKHAM, M.D., F.A.C.S.

*(Conclusion of this Study which began in the August, 1958
issue of THE LINACRE QUARTERLY)*

PART II MEDICAL CONSIDERATIONS

In hypogonadism, the hypoplasia of the interstitial cells causes eunuchoidal manifestations due to deficient endocrine elaboration. The scrotal contents may lack testicular elements entirely because of cryptorchism when neither testis has descended, or the testes may be extremely small, difficult to feel and soft in consistency. These latter conditions indicate either a failure to develop in early life or demonstrate a primary atrophy. These victims manifest variable physical patterns depending on the degree of gonadal deficiency. There may be extreme obesity with feminine body configuration, absence of normal hair distribution, voice changes, and a general loss of secondary male sex characteristics. Loss of libido and accompanying impotence are frequently seen as results of such deficiency.

The site of the primary defect will be either the pituitary or the testis, and the diagnosis can be established by biopsy of the testis when possible and the urinary assay of the gonadotrophic hormones. Cytological sex chromatin

tests are also significant. The conditions associated with hypogonadism have been classified into three categories: 1) Testicular aplasia or atrophy due to prepubertal failure of the testes — 2) The "so-called" Klinefelter syndrome — a heterogenous assemblage of cases generally characterized by high gonadotrophin, small testes with variable degrees of eunuchoidism, gynecomastia and hyalinization of seminiferous tubules. Many of these persons, by the available sex chromatin tests, are shown to be genetic females and in fact are female pseudo-hermaphrodites — 3) Hypogonadotrophic eunuchoidism. The first and second groups are the result of a primary testicular defect, while the hypogonadotrophic group, which is the most frequently noted, is of pituitary origin and is caused by deficient production of gonadotrophin. This latter defect results in a secondary depression or loss of testicular activity with the result that the testes fail to undergo maturation and, if the condition is not treated early and adequately, they remain

permanently in the infantile state. This type is designated as secondary hypogonadism. Testicular biopsy is characteristic and the urinary gonadotrophin hormone assay is low which is indicative of pituitary deficiency whereas in cases of testicular aplasia or atrophy and in the Klinefelter syndrome, the so-called primary group, the assay is high. When primary hypogonadism is found in the adult, the testes are beyond salvage and no treatment will improve the testes as such, but benefits may be attained by androgenic therapy and as, in the previously discussed indications, regression will occur if therapy is not maintained on a permanent basis. Even in the prepubertal and immediate post-pubertal period, the testicular changes are irreversible and the role of therapy, replacement and substitute, is directed towards the improvement of the secondary male sex characteristics and the subsequent accomplishment in later life of the sex act. As we have repeatedly noted, individual evaluation is fundamental. In the young male, the evaluation of potency will of necessity be delayed until later in life.

The response to anterior pituitary therapy in secondary hypogonadism is frequently dramatic. Therapy, however, should be discontinued if there is no response within six months. In those who demonstrate a beneficial reaction, spontaneous and continuous improvement has followed even after therapy has been interrupted. For some unexplained reason the previously underactive anterior pituitary has been stimulated to

maintain activity. This favorable response is manifested by increased genital growth and a general systemic hormonal improvement.

It must be appreciated that variable grades of testicular deficiency occur in both the primary and secondary hypogonads. When the ability of the hypogonad to ejaculate and inseminate has been established with or without therapy, the presence or absence of the testicular component is of paramount significance in view of the Gasparri opinion. A hypogonadal male with the ability to effect the sex act in the absence of any demonstrable condition, which might indicate occlusion of the seminal tract, can be assumed to emit a testicular component even though the presence of sperm cannot be proved. The loss of spermatogenic power which occurs very frequently, would not necessarily preclude the possibility of a testicular component in the ejaculate but at present there is no known method of determining its presence or absence.

The prognosis of potency in the hypogonad will depend on the type of condition, the age of the person and the response to adequate therapy. Modern investigators have proved conclusively that regardless of age, primary hypogonadism is irreversible, but that replacement therapy may reverse the clinical manifestations. In the so-called secondary group, however, anterior pituitary hormone administration may be not only beneficial, but curative. It must be noted that there is an indefinite group among the hypogonads

who, as they attain maturity, outgrow their stigma and without recognition and treatment are lost among normal males. Among this group are encountered the sterile males and in many instances the impotent males, who, unconscious of their inadequacies, show minor manifestations of eunuchoidism, but in whom no definite physical or psychic factors can be found. It is our personal opinion that a relatively high percentage of sterile and impotent males can be allocated to this indefinite unclassified group. These men are generally seen in early adult life, the marriageable age, and are not cognizant of their physical handicaps and apparently previous physical examinations on them have been unrevealing. Careful study will assist this group and direct proper therapy.

Hypogonadism in the male, therefore, is a definite factor in impotency as an impediment to marriage but it must be emphasized that each person must be meticulously classified by the utilization of the available diagnostic studies which will indicate the proper therapy. Thus, many of these handicapped males can be helped and a return to normalcy will enable them to contract marriage and/or to function normally in marriage.

Congenital anatomic variations of the genital system may occasionally present almost insurmountable problems. The term intersexualists has been applied to this group of individuals — and should be limited to those in whom abnormalities of sex development

have led to a confusion of the exact sex and to those with some of the reproductive organs of both sexes, and also to patients whose anatomic appearance is one sex but whose somatic chromatin is the opposite. The true sex is difficult and at times impossible to determine by external examination as the genital configurity may be ambiguous, and even after highly sensitive laboratory procedures and biopsy there may be considerable doubt, although oral cytologic smears are now believed to have confirmatory value. Meticulous abdominal exploration may be necessary in many instances. The sex of the person may be opposite to that presented by the gonads themselves. They are referred to as pseudo-hermaphrodites, and are regarded as masculinized females or feminized males. They possess the reproductive organs and the psychic characteristics of the opposite sex. In the male the external genitalia may appear masculine, but surgery reveals the presence of a uterus or other female development of internal ducts. The true hermaphrodite is relatively rare and is a condition in which the gonadal elements of both sexes are present in the same individual either as separate ovary and testis or more commonly combined as an ova-testis. The genital development and sex characteristics may be extremely variable, although generally predominant of one sex. It has been previously noted that certain types of primary hypogonadism represent a form of intersexuality. It is a deplorable fact that the recognition of the intersexuals in many in-

stances does not take place until early adult life and occasionally after marriage has been contracted. From our viewpoint this is particularly significant in these individuals with male external genitals of relatively normal configuration. Correct diagnosis may be extremely difficult but with careful inspection of genitals at birth, cytological studies and scrutiny of suspiciously abnormal sex manifestations in the early years of life, disastrous errors and future tragedy can be prevented. These individuals must be definitely considered permanently impotent although in the rare and isolated instance surgical methods may remedy the picture.

Neurophysiologic dysfunction following disease or injury affecting the centers of erection and ejaculation, or the nerves conveying impulses to (afferent) and from (efferent) the genital organs may play a primary role in impotence. These lesions may occur at any point along the nerve tract from the highest centers of the brain to the terminal peripheral nerves. The closer the lesion to the reflex centers of erection and ejaculation in the lumbar and sacral cord, the more likelihood of interference with sex function.

Peripheral nerve injury, productive of impotence, may be a secondary effect of radical surgery for the removal of serious disease. Impotence, irreversible in type, is a well-recognized sequela of total cystectomy for advanced carcinoma of the urinary bladder in which the bladder, prostate, and seminal vesicles are removed. Sur-

gical eradication of rectal malignancy is likewise frequently followed by impotence due to neurogenic dysfunction.

The problem of paraplegia presents itself quite frequently in this day and age, as the ravages of war and our highly industrial era have notably increased the incidence of this condition. In our discussion, the term paraplegia is limited to persons on whom all available measures directed to the treatment of the primary cord lesion have been employed and time has demonstrated the futility and inefficacy of the therapy. Talbot, in a personal communication, defines paraplegia — "paralysis of and loss of sensation in both lower extremities, resulting from complete or nearly complete transection of the spinal cord due to injury or disease. When the transection is in the upper portion of the spinal cord so that the upper extremities also are involved, the term quadriplegia is used. There is associated disturbance of bladder and bowel function and also of the neuromuscular component of the sexual function, but usually not complete impotence." At the present time, there is no therapy known to science which is available to the long-standing paraplegic. Thus, if an impotent condition is verified, it must be considered permanent. Obviously, this does not include the man who has a cord lesion which may readily be amenable to partial or complete cure by surgery and physiotherapy.

Talbot has reported a study of 408 cases of spinal cord injury

and disease, which were sufficiently severe to produce paraplegia and he refutes with emphasis the popular belief that all are sexually inadequate. He demonstrated that sexuality on a psychic level is essentially unaltered and that gonadal function is not materially affected. Testicular changes are generally confined to the germinal epithelium as a result of general debility, infection, and probably alteration of pituitary function associated with the severe trauma and shock of spinal cord injury. There is a high incidence of seminal duct obstruction due to sepsis. The endocrine factor is not primarily affected. It is reasonable therefore to state that the psychic and endocrine elements may remain fundamentally unaltered if the patient remains in good physical status and makes a satisfactory adjustment to his new way of life.

The neuromuscular mechanisms are drastically modified. In Talbot's series, the levels of neural involvement varied from the 5th cervical vertebra to the cauda equina. He found that 34% had lost the power of erection, 45% were able to develop an erection on local stimulation and 21% had erections as a result of psychic stimuli. Of these who attained erection as a result of local stimuli, 21% were capable of intercourse, while 66% were capable following psychic stimuli. There was a definite closer approach to normal in those with the capacity to evoke erection by psychic stimuli. The mechanism was less affected when the site of the cord lesion was above the 11th dorsal segment.

It is worthy of note that every clinic treating a considerable number of paraplegics has reported the occurrence of pregnancy among their wives. Five percent of Talbot's series proved their fertility. It must be appreciated that, in the evaluation of this group, accurate statistics are difficult to obtain as individual reactions to the problem vary considerably. Many of the paraplegic patients are hospitalized which preclude a normal way of life and affects the interpretation of findings.

In the investigation of the paraplegic's impotence every case must be studied in meticulous detail as to the type and extent of injury, the neurologic damage and the presenting sex pattern. In our practice we have encountered two instances of paraplegics who were presumed potent prior to marriage, but who were unable to consummate the union because of impotence.

Even if paraplegia exists and the individual is permanently impotent, the canonical impediment is not always present as the condition was subsequent to the marriage for example—the husband may become a paraplegic as a result of a war injury following a consummated marriage. However, if marriage was not consummated prior to injury the marriage might be dissolved on the basis of non-consummation. If the condition is antecedent but there is doubt of its permanency, the validity of the marriage would have to be upheld but the union might be dissolved on the basis of non-consummation.

It must be emphasized that

among the group of paraplegics in whom erection or ejaculation has been effected by local, tactile and psychic response, no particular pattern has been demonstrated. The picture, according to reports, has varied from a transient incomplete non-sustained erection with or without ejaculation to an occasional sustained erection with or without a satisfactory ejaculation. At times the erection is insensible. Libido has been a variable factor as well. In most instances, however, the ejaculation has been in the form of the so-called distillate of urethral origin rather than the true emission of the normally accepted origin. Unfortunately, and extremely pertinent to the present problem, most of the studies, which have been carried out among paraplegics, have been based on the attainment of erection and ejaculation in the achievement of masturbation rather than the goal of normal conjugal sexual accomplishment. Talbot, however, has reported as mentioned above successful pregnancies in this group. Erection and ejaculation in these individuals is certainly not spontaneous and is effected only with a great deal of effort by both psychic stimulus and by local manipulation on the part of the partners involved.

In this whole discussion, it must be noted that in the conclusions reached, specific information about the site and extent of neurologic trauma must be elicited as well as a careful history of the individual's libido and reaction to the accepted moral sex stimuli. A most confidential and frank discussion of his sexual reactions to

his aspired spouse must be minutely and carefully evaluated and it must be premised on an acceptance of mutual confidence between the involved male and the questioner.

There may be a definite derangement of sex function, temporary or permanent, as a secondary or side effect of operations on the sympathetic component of the automatic nervous system. It is logical to expect that if a portion of the sympathetic pathways is interrupted to modify a particular disease process, unrelated physiologic mechanisms will also be affected. These operations include transthoracic splanchnectomy and sympathectomy, lumbodorsal splanchnicectomy and sympathectomy. Impotence, as a result of disturbance with centers of erection and ejaculation have been observed. Whitelaw and Smithwick, in an excellent treatise, reviewed from this point of view 161 persons who had undergone such surgery.

As previously noted, the sympathetic fibers innervate the smooth muscles of the *vas*, seminal vesicles and prostate and are also a factor in contraction of the internal sphincter. After sympathectomy, there may be interference with the contraction of these smooth muscles with resultant failure of ejaculation into the posterior urethra and what emission is present may enter the bladder due to the relaxed internal sphincter.

In the process of erection the neurogenic pathways are almost wholly parasympathetic and the

erectile disturbances cannot be entirely explained but it is probably due to vaso-constriction of the penile vessels due to circulating adrenin and to the shunting of blood to the viscera and resulting diminished circulation to the genitals. In the transthoracic procedures, there has been no permanent loss of ejaculation and the loss of erection has been mild and transitory.

In Whitelaw's series, there were 116 lumbo-sacral operations in which significant disturbances of erection were noted in 27% and of ejaculation in 26%, and 19% of the latter were permanent. It has been demonstrated that if the derangement has not returned to relative normalcy after six months, the condition will probably be permanent. In the evaluation of this type of impotence, the indications for surgery must be determined, the date of surgery and the technical procedure carried out in the particular case should be obtained.

Following the lumbo-sacral procedure there should be no interference with sex function if operation is not extended to include L-1 on one side and D-12 on the other. In bilateral cases, there should be no interference if the operation is not extended to include L-1 on either side. When L-1 to L-3 are included significant changes may be expected to occur in a high percentage of cases. It must be appreciated that there is a great anatomical variation of the sympathetic system especially in the ganglia of the lumbar area, but, when necessary, certain sur-

gical modifications may be warranted to eliminate the side effects and thus insure the preservation of sex function in the individual patient.

It is obvious, from the above-mentioned statistics, that an impotent condition can result as a secondary development and side-effect of sympathectomy surgery. However, no general statements or principles can be set forth as the gravity and extent of any injury must be investigated in each individual case to determine if there has been any disturbance of the centers controlling the processes of erection and ejaculation. If such has been demonstrated, the temporary or permanent nature of the condition must be considered. If the impotency has been proved to have been antecedent but a doubt arises as to its perpetuity, the impediment of impotency cannot be established, the marriage must be held to be valid but there remains the possibility of a dissolution on the grounds of non-consummation.

If the condition is detected before a contemplated marriage takes place and a doubt of the permanency of the condition arises, the marriage cannot be prohibited, but if after the marriage, the permanency has been demonstrated with greater certainty, the marriage could be declared invalid.

Complete impotence is a common sequela of prostatic surgery, especially following radical perineal prostatectomy for cancer in which the posterior urethra, prostate and seminal vesicles are re-

moved. Loss of sexual power following surgery for the removal of benign prostatic obstruction varies with the type of procedure carried out. The incidence of such loss following transurethral measures is relatively low, although the interference with ejaculation is greater when a large portion of the gland is resected. When open surgery is performed, impotence is less likely to occur after the suprapubic procedure than following the perineal approach, in which complete impotence is the rule rather than the exception. The ability to attain and maintain an erection may not be significantly modified, but the ejaculate is reduced to a minimum or is completely absent since the component of the prostate and probably the vesicles and testes are eliminated and the ejaculate, if present at all, is formed by the glands of Cowper and of Littre. It must be appreciated that in this group of cases, except in the isolated instance, the problem of impotence as a marriage impediment is not presented as the great bulk of the patients are in the evening of life and normal testicular involution is taking place.

As indicated, there may be little interference with the power of erection by reason of prostatic surgery. However, there can be a serious diminution in the content of the ejaculate and, in some instances, there is no ejaculation at all. It is very important, in such cases, to determine the diagnosis and receive a complete record on the surgical procedure followed and the organs which have been excised.

If there has been any interference with the normal continuity extending from the testes to the urethral orifice, so that it can be said that no testicular component is to be found in the ejaculate, then the impediment of impotency must be said to be present under the Gasparri opinion, since the surgery is irreversible and the organs, once removed, cannot be restored. This presumes that the condition existed at the time of the marriage, which is not too likely, since this type of surgical intervention is usually found only in aging men. If there is no ejaculation at all or the amount is seriously diminished, so that it cannot be said to be that of a normal man, there is even the possibility of declaring the marriage invalid under the terms of the modern opinion. Bilateral vasectomy at the time of or immediately prior to prostatic surgery is a common practice and obviously totally and completely eliminates the testicular component which would be a consideration, if the Gasparri opinion is to be invoked.

The late effects of the interference with the integrity of the blood supply to the testes are occasionally encountered following surgical repair of inguinal hernia. It has been demonstrated that even temporary interference may result in irreversible damage. This is particularly damaging when the changes are bilateral. We have personally noted several cases of bilateral testicular atrophy in the young adult which had its origin in the surgical repair of bilateral herniae in childhood. Impotence, and especially sterility, may be the

sequelae in such cases. Testicular dysfunction will vary with the degree and type of injury. If the *vas* is ligated or cut and the findings are bilateral, sterility will follow. If loss of integrity of the blood supply results, complete testicular atrophy may result with associated elimination in whole or in part of the androgenic function. Substitute therapy is indicated in these cases after adequate studies have been carried out. Infarction of the spermatic cord may result in testicular atrophy unless recognized early and managed promptly.

Varicocele is generally insignificant but in a rare example, atrophy of the testis may occur.

Mumps orchitis in the young adult may, in severe cases, cause permanent loss of spermatic function, but is rarely a factor in impotence. Thrombosis of the distal aorta (Leriche's Syndrome), manifested by absent femoral pulse, back pain, claudication and impotence, is not infrequently encountered in the young male adult. In this disease, modern surgery has at least been temporarily successful and only time alone will prove its value. Excision of the involved portion of the aorta is performed and is replaced by a graft.

Occlusion of the excretory pathways leading from the testes to the upper seminal tract is a frequent cause of sterility and in the light of the opinion of some canonists and moral theologians must also be considered a significant factor in impotence.

The interruption of the continuity of the *vas deferens* by simple ligation, division, or segmental

resection is a standard procedure among urologists in doing prostatic surgery in order to prevent the spread of infection from the prostatic bed to the epididymis. Vasectomy, so-called, is often performed, in the absence of medical indications, to effect sterilization. Eugenic and punitive sterilization, by this method is a common practice. Inadvertent injury to the *vas* may occur in the surgical correction of hernia, hydrocele, varicocele and undescended testicle. Spontaneous re-canalization has taken place following simple ligation. Congenital maldevelopment of the vasa-epididymal tract has been observed and is probably more common than reported, as in the absence of external manifestations, there is nothing to direct the attention of the individual to the condition and recognition may be made only at the time of surgical exploration. The *vas* may be absent, particularly in the scrotal portion, or there may be failure of fusion with the epididymis. Absence of the epididymis has also been reported. Epididymitis, non-specific, post-gonorrheal, or tuberculous in origin, frequently results in occlusion of the *vas* or epididymal tubule and when bilateral, the testicular component of the ejaculate may be entirely lacking. Epididymectomy is a surgical procedure in tuberculosis and chronic intractable infection of the epididymis, and when bilateral, permanent loss of continuity between the testes and the posterior urethra is effected.

Surgical attempts to restore *vas* continuity after vasectomy have been carried out with variable suc-

cess. Except in the hands of a few enthusiasts, however, the operation has not been performed. O'Connor in 1948 sent 1240 questionnaires concerning vas anastomosis to qualified urologists. He received responses from 750 doctors of whom fewer than 17% had ever attempted the operation. 135 urologists had performed 420 operations and reported a success of 38%. The vasectomized person who desires or requests restoration is rarely encountered and no surgeon is able to acquire a large group of cases. O'Connor, however, in 1953 reported successful results in 63% of thirty cases.

Post-inflammatory constriction of the vasa-epididymal ductal system may likewise be amenable to corrective surgery by creating a new and patent passage for the conduction of the testicular component. The tail of the epididymis (globus minor) and the adjoining portions of the *vas* are more likely to have the most dense scar. Several techniques have been devised for anastomosis of the *vas* and epididymis including anastomosis of the *vas* with an individual epididymal tubule or with a spermatocele. The most frequently employed procedure is the anastomosis of the *vas* to the head of the epididymis (globus major), thereby shunting the sperm along a new conduit. O'Connor operated on sixty-one men with bilateral chronic non-tuberculosis epididymitis with a resultant occluded epididymis and reported 8-10% success. Simmons states that, in proper hands, with highly selected cases the surgeon may expect relief in about one-third of obstruct-

ed epididymis cases and he decries the defeatist attitude concerning this technically difficult procedure and makes a plea for "more and better anastomoses." There are several reasons for the high percentage of failure in this type of surgery: the minute size of the lumen, the tendency to scar formation at point of union, the friability of epididymal tubule, tension on the anastomosis, the high incidence of infection and the technical inefficiency of the surgeon in the particular procedure.

It is reasonable to expect that the success of the vas anastomosis procedure will be greater as the success of the *vas* anastomosis approximation of tubular structures of comparable size. When surgical attempts are made to circumvent occlusion of this system they should be preceded by tests to determine the patency of the lumen above the block and to prove the integrity of the testis by biopsy. It can be stated without fear of contradiction, therefore that occlusion of the *vas* and epididymis may be reversible and amenable to surgical restoration. The surgical procedures, although technically difficult, entail no mortality, slight morbidity, and, even if unsuccessful, result in no permanent disability.

In commenting on these conditions, it might be mentioned that, in cases of vasectomy and occlusion of the epididymis, the power of erection and ejaculation in the individual is not disturbed in any way. However, the ejaculate will contain no testicular component and will consist mainly of fluid provided by the seminal vesicles,

the prostate gland and the bulbo-urethral glands.

Since the modern opinion requires no testicular component in the ejaculate, cases of double vasectomy and bilateral occlusion of the epididymis will not constitute an impotent condition and regardless of the temporary or permanent nature of the condition, these will never constitute the impediment of impotency.

Inasmuch as the classical opinion of Cardinal Gasparri requires a testicular component in the ejaculate, the conditions of double vasectomy and bilateral occlusion of the epididymis, because there is an obstruction in the continuous channel, leading from the testes to the urethral orifice, would constitute an impotent condition. The important question that arises is whether or not this occlusion or obstruction can be reversed by the surgical procedure known as anastomosis. This particular technique requires great skill, if the effort is to be successful and yet very few surgeons have had the opportunity or have taken advantage of the opportunity to perform an anastomosis. Thus, there is serious question as to the successful outcome of this type of surgery in the hands of most surgeons. Even at best, O'Connor only reports 63% success in thirty cases of double vasectomy. Since this represents a very limited series, the results are not conclusive and the statistics cannot be taken on face-value. He points to only 8-10% success in his surgical efforts on sixty-one cases of bilateral chronic non-tuberculous epididymitis. This is a negligible percentage, when

it is considered that he has had much more experience in this particular type of surgery than the greater number of surgeons.

In view of the above statistics, it must be admitted that there exists the possibility of once again restoring the continuous pathway from the testes to the urethral orifice but the probability is open to serious question when a surgeon, inexperienced in this specialized and difficult type of surgery, attempts to undertake it.

Many authors believe that the repair surgery, while it does not involve any danger to the life of the individual and is licit, still has only limited probability of success; that this type of surgery cannot be considered an ordinary means and therefore, the conditions of double vasectomy and bilateral occlusion of the epididymis are to be considered permanent.

Cappello states that the possibility of a cure is to be evaluated not absolutely but relatively, by taking into consideration the important circumstances of person and place. Thus, if a person has undergone a double vasectomy operation or is suffering from bilateral occlusion of the epididymis and is living in an area where there are no surgeons with any experience in anastomosis surgery, and the possibility of a successful outcome is thereby diminished, the condition might well be termed irreversible and permanent.

On the other hand, where the possibility of a remedy is at least theoretically at hand, the permanency of the condition might be considered to be doubtful. In this case, the impediment of impotency

could not thereby be verified and a contemplated marriage could not be prohibited and a marriage, already contracted, must be considered to be valid, since at least a doubt of fact is said to exist. All of this consideration is under the Gasparri opinion, since the modern opinion would not consider these conditions, even if permanent, to constitute impotency.

CONCLUSIONS

1) An impotent condition, whether on the part of the man or on the part of the woman, whether absolute or relative, which has certainly been proved to have been antecedent and permanent, constitutes a diriment impediment, with basis in the natural law, and prohibits a marriage to be contracted and nullifies a marriage that has already been contracted.

2) An impotent condition will be considered antecedent if it has been proved to have been congenital or if the surgery, or accident, which accounted for it, antedated the marriage in question.

3) An impotent condition will be judged permanent, if absolutely no cure or remedy exists or if an actual cure was considered to have been effected by miraculous intervention rather than by natural means or if an existing remedy is judged to be illicit, immoral or sinful by reason of the means employed, or if it presents a danger to the life of the patient. The availability of a remedy must be judged on a relative rather than on an absolute basis, taking into consideration how advanced and modern is the medical and surgical practice in the area where the patient resides. If a remedy is

readily available but the impotent person refuses to submit to the required surgery or therapy and the impotency persists, the condition must still be judged to be temporary and not permanent. However, in such an eventuality, the other party might seek a dissolution of the marriage on the ground of non-consummation. Because medical science, through experimentation and research, is making rapid strides in conquering and finding cures for many illnesses, it is very possible that an impotent condition, considered permanent today, might be thought only temporary in the years to come and thus that which might prohibit or invalidate a marriage today will not be considered an impediment in the future. If a doubt arises as to the temporary or permanent nature of an impotent condition, the impediment of impotency cannot be said to be present and, therefore, a contemplated marriage cannot be prohibited or a contracted marriage cannot be invalidated but the possibility remains of having a marriage dissolved on the basis of non-consummation.

4) It is unanimously accepted that male potency requires the presence of a normally constructed and developed male organ, which is capable of being erected and of being sustained in erection long enough to penetrate the female vagina and to seminate within it.

5) What constitutes proper semination is a matter of controversy at the present time. The followers of Cardinal Gasparri demand that a testicular component be contained in the ejaculate and

therefore, in addition to the above-mentioned requirements, there should also be present at least one healthy testicle, which will elaborate some proper liquid over and above the spermatozoa and this liquid should pass through an uninterrupted passage from the testicle through the *vas deferens* and seminal vesicles to the urethral os and ultimately be deposited within the vagina of the woman at the moment of ejaculation. The devotees of the modern opinion would not demand any testicular component in the ejaculate or an uninterrupted passage from the testicles to the urethra and would require only a satiative copula to be effected by a semination from the seminal vesicles, prostate gland, Cowper's gland and the bulbo-urethral glands. Those favoring this opinion would usually insist on the presence of at least one healthy testicle, which, by its elaboration of androgen hormone, would account for the erection of the male organ. However, the present writers feel that if an erection can be experienced and sustained by maintaining the proper androgen level through the administration of a synthetic hormone in a male who had properly developed testicles up to puberty, then this modern theory should not require the presence of even one healthy testicle in those instances. Since synthetic androgen therapy is not effective in every instance, each case must be studied individually and decided on its own merits.

6) Since the Gasparri opinion and the modern opinion both enjoy probability, intrinsically and extrinsically, either can be pre-

ferred or invoked or there remains a third possibility, in the opinion of the present writers, that, because certainty does not exist on either side, a judgment can be made that a positive and probable doubt of law exists. Because of this doubt of law, in instances where at least one functioning testicle is not had or a testicular component is not present in the ejaculate because of the absence of the testicles or because of some irreversible obstruction along the passage, leading from the testicle to the urethral orifice, an anticipated marriage cannot be impeded or a contracted marriage cannot be declared null.

7) Although some few medical anomalies can be readily considered as impotent conditions and, because of their permanent nature, can be judged to constitute the impediment of impotency as well, yet, in most instances, an unqualified and categorical answer cannot be given but rather the individual, specific symptoms and factors of each case must be studied and analyzed before it can be determined that a given condition is one of impotency or that an impotent condition is permanent.

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Current Literature: Titles and Abstracts

The purpose of this department in THE LINACRE QUARTERLY is to make available by titular listing such current articles as are thought to be of particular interest to the Catholic physician by virtue of their moral, religious, or philosophic implications. It is not limited to the medical literature although, of necessity, this source is the most fruitful. When abstracts appear, they are intended to reflect the content of the original article. Parenthetical editorial comment may follow the abstract if considered desirable. Contributions from readers are invited.

Beecher, H. K.: Experimentation in man, *J. A. M. A.*, 169: 461-478, January 31, 1959.

Human experimentation is almost as old as man. The need for careful periodic re-examination of the subject has always existed but has become more acute with the rapid advance of science. The large-scale Nazi experiments have added further urgency to such re-examination. The writer, who is Chief of Anesthesiology at the Massachusetts General Hospital, has prepared this paper as a report to the Council on Drugs of the American Medical Association. It is a comprehensive, scholarly, and valuable review. Historical, social, legal, and ethical aspects are carefully discussed. The views of the Church as expressed by the late Pope are accorded full consideration.

Connery, J. R. (S.J.): A theologian looks at the Wolfenden report, *America*, 98: 485-486, January 25, 1958.

In September, 1957, a British committee studying penal laws relating to sex offenses, under the chairmanship of Sir John Wolfenden, presented its report to Parliament. Father Connery summarizes the major findings of this committee and discusses them from the standpoint of moral theology.

Galdston, I.: Job, Jung and Freud: an essay on the meaning of life, *Bull. N. Y. Acad. Med.*, 34: 769-784, December, 1958.

With the *Book of Job* as a focal point, and the philosophical systems of Jung and Freud for atmosphere, the writer presents his concept of the meaning of life. Freud, he states, "was compulsively obsessed with the rejection of that infantile consolation which Christianity and the later corrupted Judaism offered to the credulous, the belief in a life here-after.

... But there is vastly more to Christianity than the myths of resurrection and Judgment Day, and more to Judaism than the archaic laws of Kashris. The totality of religion cannot be judged an Infantile Illusion. Religious faith is the supreme achievement of the human spirit, infinitely higher and greater than either Art or Science. For without it there would be no humanity, and hence no Art or Science."

Cohen, M. R.: Sterility and infertility—medical views, *J. A. M. A.*, 168: 1963-1970, December 13, 1958.

Diagnosis and treatment of sterility and infertility in both man and woman are reviewed. The age of the wife at the time of marriage bears a direct relationship to sterility. Contraceptive measures *per se* have little effect on infertility but serve to place the wife in an older age group with a statistically higher incidence of infertility.

Code of ethics for hospitals, *J. A. M. A.*, 169: 987, February 28, 1959.

This is the recently revised 10-point code of ethics for hospitals adopted by the American Hospital Association and the American College of Hospital Administrators. A similar code for hospital administrators is also outlined.

O'Driscoll, M. K., Barry, A. P., and Drury, M. I.: Rheumatic heart disease complicating pregnancy. *Brit. Med. J.*, 2: 1090-1091, 1957.

In 289 instances of rheumatic heart disease in pregnancy there was only one maternal death. Mitral commissurotomy was performed on three occasions (1%). No cesarean section or induction of labor was undertaken for heart disease, and no therapeutic abortion was performed. The cases were unselected and from poorer classes in a population where contra-

ception, abortion, and sterilization are not practiced by the community. According to the authors, "The results justify the conclusion that, no matter how serious the rheumatic heart condition may be, pregnancy should not be terminated at any stage, nor should abdominal delivery be resorted to." — R.J.C.

Burwell, C. S.: The special problem of rheumatic heart disease in pregnant women. *J. A. M. A.*, 166: 153-158, January 11, 1958.

A total of 298 pregnancies in women with rheumatic heart disease resulted in only three maternal deaths. There was no evidence that the pregnancy, once survived, accelerated the course of the heart disease. There are three possible approaches to the management of rheumatic heart disease in pregnancy: 1. therapeutic abortion: "This is not a good solution. The fetal mortality is 100%. There is some risk to the mother even early in pregnancy. Psychologically the effects are generally bad, and the procedure is often quite unacceptable to the patient. Happily, as our own experience of heart disease is accumulated, the number and per cent of interruptions have diminished and this procedure is now rarely indicated. In the last eighteen months of the period of our experience under scrutiny, interruption was advised only once." 2. surgery: The author does not favor it, even in mitral stenosis during pregnancy; he feels it is almost never necessary and carries special risks. 3. conservative medical management: This is advocated by the author in the vast majority of cases. — R.J.C.

Taylor, W. J., Black, H., Thrower, W. B., and Harken, D. E.: Valvuloplasty for mitral stenosis during pregnancy, *J. A. M. A.*, 166: 1013-1018, March 1, 1958.

The writers report 27 cases of pregnant women who underwent valvuloplasty for mitral stenosis. There were three maternal deaths, two of which were thought to be unrelated to the pregnancy. Twenty healthy children resulted. Twenty-three of the mothers were moderately to markedly improved over their pre-pregnant state. The authors feel that in some cases valvuloplasty is justified. They also express the opinion that there is a place for therapeutic abortion in pregnant women with surgically uncorrectable heart disease, but rarely, if ever, in pure mitral stenosis. — R.J.C.

Greenberg, M., Pellitteri, O., and Barton, J.: Frequency of defects in infants whose mothers had rubella during pregnancy. *J. A. M. A.*, 165: 675-678, October 12, 1957.

The authors point out the need for prospective studies to determine the true incidence of congenital defects in the children of mothers with rubella during the first trimester of pregnancy. In their study they include one-hundred and four women who had rubella during the first trimester. Forty-six per cent underwent therapeutic abortion, 27% gave birth to normal infants, 3% to congenitally malformed babies, 3% to still-births, and 12% to other non-viable fetuses. Ten per cent of the cases were lost from the study. The incidence of congenital deformities among live-born babies of these women was 9.7%. The available data indicate that approximately 12% of offspring of such women will be live-born with congenital defects. The fantastically high rates set by earlier authors were based on retrospective studies of malformed infants, and did not account for babies who were born normal and who therefore escaped study. Thus many of the previous studies were incorrect. The authors state: "Blanket advocacy of therapeutic abortion in pregnant women who develop rubella during the early months of pregnancy is medically unjustified." They do advocate the exposure of susceptible young girls to cases of rubella as a prophylactic measure. — R.J.C.

Editorial: Rubella in pregnancy. *J. A. M. A.*, 165: 688, October 12, 1957.

Various studies indicate that the incidence of congenital malformations or still-births in cases where the mother acquires rubella during the first trimester of pregnancy is 16.5 to 20%. There is one favorable report on the use of convalescent serum from rubella patients in the treatment of women exposed to rubella during pregnancy. The editorial includes the statement: "The fact that the chances that the infant will be normal in spite of the mother's infection are much better than was formerly thought seems a valid reason not to interrupt the pregnancy." — R.J.C.

Blattner, R. J.: Rubella during pregnancy, *J. Pediat.*, 54: 257-260, February, 1959.

All facets of the problem posed by maternal rubella during pregnancy are explored and evaluated. The advisability of performing therapeutic abortion in this situation is discussed. Statistically it has

been shown that the fetus is most susceptible to serious damage from maternal rubella in the very early (first four) weeks of pregnancy, and patients in this group are likely candidates for therapeutic abortion.

Rubella occurring from the sixth to eighth week of gestation is a less strong indication for interruption of pregnancy, and abortion is definitely not advised for patients who contract the disease after the twelfth week. Although the hazard of congenital malformation following rubella in the pregnant woman is less than earlier reports suggested, nevertheless "the risk is still a real one, often with tragic consequences for the individual and his family."

Krumbhaar, G. D.: Functions of a hospital chaplain, *Current Medical Digest*, 25: 61-65, December, 1958.

The writer of this article, which was reprinted from the April-June, 1958 issue of *Bulletin of Tufts—New England Medical Center*, was actively engaged in the practice of obstetrics and gynecology for twenty-one years prior to entering the Episcopalian ministry in 1957. He thoughtfully delineates his concept of the role that the hospital chaplain should play in patient management, and pleads for a certain amount of friendly *apartheid* on the part of those concerned with the physical and spiritual welfare of the patient.

(One argument advanced has a somewhat humorous twist: "A minister is not a physician, nor a psychiatrist. You will find many ministers who disagree violently with this statement. They believe that man is related to God through his reason and that since psychiatry deals with the reason, they are, or should be, psychiatrists. I am sure that they would be somewhat confounded were they to realize fully that this is a return to the teaching of St. Thomas Aquinas, the great medieval scholastic on whose doctrines much of Roman Catholic theology is based!")

Wheeler, W. F.: Priestly counseling in a mental hospital, *Bulletin of the Guild of Catholic Psychiatrists*, 5: 28-33, April, 1958.

For a priest, counseling in a mental hospital is essentially the same as counseling anywhere else. Ordination does not make him a psychiatrist. His purpose is to look after the welfare of the immortal souls entrusted to his care. He uses the ordinary means: teaching revealed doctrine and truths, saying Mass,

and administering the sacraments. His main duty is **not** the cure of the mentally ill. The ideal is for the priest and the psychiatrist to work together. Both are interested in the welfare of the patient, one as psychiatrist, the other as priest.

The priest must have the attitude of respect for the dignity of the individual, and above all, the attitude of kindness. Though a priest can and should be "permissive," i.e., he can "permit" the person to discuss any matter whatsoever, he must have an attitude of authority in showing the Church's laws and teachings as applied to his case.

Many of the problems that face the chaplain of the mental hospital are the same as occur in the rectory. He spends much time counseling relatives, who possibly feel guilty, or who feel that nothing is wrong with the patient; in bearing the grief of the patient's death, and helping in cases of autopsy. The priest must bear in mind that he is primarily a priest, though some knowledge of mental illnesses and their treatments will prove beneficial to him. His attitude must be that he counsels, not primarily mentally ill who happen to be Catholics, but Catholics who happen to be mentally ill.

— D. MacD.

Chicanot, E. L.: Medicine and conscience, *America*, 100: 632-633, February 28, 1959.

The matter of refusing emergency blood transfusions on religious grounds has become a burning topic in Canada as the result of the death from gun-shot wounds of a child in Manitoba. The patient's parents had declined, because of religious convictions, to permit administration of blood. Medical, legal, and public opinion has been divided on the subject. In the eyes of the author, "The essential issue is a baffling and complex one to the thinking layman, who can see on the one hand the apparently needless deaths of innocent children but on the other hand an incursion into the fields of personal liberty and parental rights, and an infringement on religious freedom."

(In the same issue of *America* an editorial, "Man, Morality and Medicine," page 625, reviews this problem against the back-drop of natural law as emphasized in the discourses of Pope Pius XII.)

Nelson, H. A.: Medical ethics — choice for right, *J. A. M. A.*, 166: 1309-1312, March 15, 1958.

This paper stresses the need for proficiency in the humanities as well as in

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science to serve one's patients and one's community properly. The author gives a detailed discussion of the present "Principles of Medical Ethics of the American Medical Association." — R.J.C.

Connell, F. J. (C.S.S.R.): The morality of a kidney transplantation, *Am. Eccl. Rev.*, 138: 205-207, March, 1958.

God allows a person a certain limited dominion over his bodily integrity. All theologians allow blood transfusions. On the same ground it can be argued that God allows the transfer of organs from one living person to another as long as the operation does not gravely endanger the life of the donor and does not impair his functional integrity.

A surgeon or donor can be assured that they are on safe moral grounds if they should participate in a kidney transplantation. — C.A.W.

Christie, J. (S.J.): Moral confusion in England, *America*, 99: 109-110, April 19, 1958.

This is a brief but pertinent discussion of the moral aspects of artificial insemination donor (A.I.D.), a question that has recently been widely debated in Great Britain.

Priest, F. O., Gilchrist, R. K., and Long, J. S.: Pregnancy in the patient with ileostomy and colectomy, *J. A. M. A.*, 169: 213-215, January 17, 1959.

The authors report seven women with ileostomy and colectomy who had ten live births in ten term pregnancies and three early spontaneous abortions. There was no maternal mortality. Nine of the ten deliveries were *per vaginam* and one was by cesarean section. One patient developed intussusception at six months and required two operations on her ileostomy plus cesarean section. The authors conclude that women with ileostomy and colectomy may undergo pregnancy with the expectation of a normal delivery in most cases. They further state, however, that pregnancy may often bring about adverse effects in uncontrolled ulcerative colitis and that it is sometimes "necessary to interrupt the pregnancy in the interest of the life of the mother."

— R.J.C.

Smith, R. B. W., Sheehy, T. W., and Rothberg, H.: Hodgkin's disease and pregnancy; case reports and a discussion of the treatment of Hodgkin's disease and leukemia during pregnancy, *A. M. A. Arch. Int. Med.*, 102: 777-789, November, 1958.

As stated by the writers, 'Hodgkin's

disease complicated by pregnancy constitutes a situation in which the mother is burdened by two proliferating systems, the disease and the fetus. One demands elimination or control, the other, preservation." In the authors' series from Walter Reed Army Hospital there were twenty-one pregnancies in eighteen patients with Hodgkin's disease. In no case did the pregnancy exert either a deleterious or a beneficial effect on the disease process. Treatment included radiation and chemotherapy. Therapeutic abortion was not performed in any instance. The writers cite Myles as indicating that "interruption of pregnancy is justified only when the disease urgently requires treatment and is localized in the abdominal or inguinal region and adequate radiotherapy is prevented by risk of injury to the fetus or where deep radiotherapy has been administered to the abdomen during every early pregnancy." They feel, however, that alkylating agents are preferable to irradiation when treatment of lesions near the uterus is necessary. Therapeutic abortion is not recommended if cytotoxic drugs in usual dose are used in the latter trimesters of pregnancy, and it is also probable that the use of small doses of alkylating agents even in the first trimester is not an indication. If large doses have been administered in this period, interruption of pregnancy may be justified. It is felt that leukemia is not ordinarily an indication for therapeutic abortion.

Lawyer, T., Jr.: Multiple sclerosis, *Med. Clin. N. A.*, 651-653, May, 1958.

In this review article the writer discusses the etiology, pathology, symptoms, physical findings, differential diagnosis, and treatment of multiple sclerosis. He mentions that pregnancy has often been implicated as responsible for the onset of the disease or for its exacerbations. There is no evidence that the former is correct. Regarding exacerbations, he states that "it has been my experience that patients with multiple sclerosis as often improve as worsen during pregnancy. Termination of pregnancy because of the presence of the disease should be recommended only after careful consideration of all the pertinent factors in a given patient."

Socialized medicine penalizes Catholics, *The Pilot*, Boston, January 6, 1959, page 2.

This is a summary of an article appearing in the *Catholic Herald*, a na-

tional weekly, by a priest writing under the pseudonym "Sacerdos." The author states that it is "virtually impossible" for a Catholic gynecologist to accept a post in Britain's version of socialized medicine. This has led directly to a steady decrease in the number of well-trained ethical Catholic specialists in gynecology.

Under the present laws contraceptive advice is to be made available to anyone who requests it and therapeutic abortion is to be performed whenever medically indicated. Thus, the author states, "a Catholic can be excluded from a hospital post by the hospital committee simply on the grounds that his views run counter to the spirit of the Act and that he would, therefore, not be a suitable person to be a consultant to or in medical charge of a maternity department."

The author then states, "This is not only a grave disability for a Catholic doctor. It means that Catholic mothers are penalized. A Catholic mother in a hospital finds that when moral questions concerning child-birth and marriage come up, she will get medical advice often against her Catholic principles from non-Catholic doctors." — J. W. O'G.

Fagley, R. M.: The population problem and family planning, *The Ecumenical Review*, 9: 1, 14 pp.) October, 1958.

Overpopulation is becoming a progressively more pressing problem. Effective family planning is "an indispensable ingredient in an adequate approach to the population explosion." The chief source of opposition to contraception is the Roman Catholic Church. The Augustinian doctrine of procreation as the sole end of marriage has been broadened by the Church to include a consideration of its secondary ends. Formal but cautious approval of period continence as licit was given by the Sacred Penitentiary in 1853. "Efforts by medical scientists to give periodic continence a more 'secure basis' have been directed towards development of a more reliable test for ovulation and development of drugs to regularise the feminine cycle. . . . The very thin line between a presumable sanction for drugs to make periodic continence a more reliable means of birth control, and presumable opposition to oral contraceptives as to all other 'artificial' means of birth control, is where the Roman Catholic position now stands. . . . Those who try to adapt, without basic revision, the Augustinian position to the needs of responsible parenthood

find themselves on the knife edge between birth control by means of pills to inhibit ovulation, which may be 'shameful' and 'intrinsically vicious,' and birth control by means of pills to regularise ovulation, which may be licit. It is not an easy position to maintain."

Fame, F.: Contribution to the study of pregnancy and pulmonary tuberculosis *Schweiz. Ztschr. Tuberk.*, 15: 14-23 1958.

In a seventeen-year period there were twenty-eight pregnancies in nineteen women hospitalized for far-advanced pulmonary tuberculosis. No adverse effect on the disease process could be ascribed to pregnancy, parturition, or post-partum activity. Collapse therapy and anti-microbial drugs were utilized as indicated.

Hall, J. A. and Gruver, D.: Religion and medicine: the opinions of medical students, *The New Physician*, 8: 31-34, 69-70, February, 1959.

This paper summarizes the results of a questionnaire circulated among the students at Southwestern Medical School, Dallas, Texas, in an effort to determine the opinions of medical students on fundamental religious and ethical beliefs. A total of 208 questionnaires were returned. Questions posed ranged from belief in a personal God to euthanasia and therapeutic abortion. The sampling is admittedly small and the authors wisely refrain from generalizing but merely present the results "with a minimum of comment." Belief in God was held by 179, 17 were agnostic, and 3 were atheist. However, a mere 27% stated that they believed all the creeds of their religion or denomination. Forty-six percent would perform abortion when indicated for the mother's health. "Should an indicated medical procedure conflict with the patient's religious beliefs, 140 of 190 answering felt they would still urge the procedure."

Connell, F. J. (C.S.S.R.): The moral aspects of a breast-milk bank, *The Liguorian*, 47: 16-17, February, 1959.

In response to a query from a physician, Father Connell discusses the moral aspects of breast-milk banks. Only under the most extraordinary circumstances, such as a mother depriving her child of sustenance by selling her breast-milk, does a moral problem arise. In general, there are three situations in which a woman may licitly donate or sell breast-milk to a "bank": 1. when her own

child has died, 2. when her supply of milk is in excess of that needed for her child, and 3. when her child is being fed satisfactorily by means other than breast-milk.

The writer states that the obligation to nurse does not bind gravely at the present time, when prepared foods are readily available. As support for his general thesis he recalls the age-old practice of "wet-nursing" and indicates that the survival of St. Therese of Lisieux as an infant was possible only in this manner.

Friedman, G. A.: Is sterilization a legal trap?, *Resident Physician*, 5: 78-86, January, 1959.

In this discussion of the purely legal aspects of sterilization the author cautions that his query may often be answered affirmatively. He briefly reviews pertinent legislation and indicates under what circumstances the performance of sterilization may be legally hazardous for the physician.

Madigan, F. C.: Do religious die younger?, *America*, 98: 562-564, February 15, 1958.

As recently as 1925 statisticians commonly held that the longevity of Catholic religious was considerably less than that of the general population. They based this opinion chiefly on the assumption that the vow of chastity and religious discipline unfavorably affect health. Fecher in 1925 conducted an extensive survey which tended to disprove this generalization. However, there were several promising avenues left unexplored in this early study. The author's investigation was prompted in part by a desire to pursue the question further. He summarizes his results as follows: "In the decade 1940-1949, Brothers just entering religion at 15 years of age could expect to live to an average age of 71.3 years, while the average native white man of 15 could look forward to reaching only 68.3 years of age. At 15, the average Sister could look forward to reaching

the ripe old age of 75.2 years, but her counterpart outside the cloister could expect only 72.7 years of life. During the period 1950-1954, Brothers and Sisters entering religion at 15 could look forward respectively to ages at death of 72.1 years and 78.0 years, but white men and women of the general public to being only 69.4 and 74.9 years of age, respectively.

Books that might be of interest to THE LINACRE QUARTERLY readers:

Linn, Louis, M.D. and Schwarz, Leo. W.: *Psychiatry and Religious Experience*. 307 pp. New York: Random House, 1959. \$4.95.

Gebhard, Paul H., Pomeroy, Wardell B., Martin Clyde, and Christenson, Cornelia: *Pregnancy, Birth, and Abortion*, 282 pp. Illustrated. New York: Hoeber, 1958. \$6.00.

(This is the third of the well-known "Kinsey Reports" to be published. Like its forerunners, it is based on detailed interviews, and in this instance analyzes the marital and gestational history of some 7,000 women, largely with a sociologic bias.)

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REV. PAUL L. GORIEU, O.M.I.

The Catholic Physicians' Guilds of Indianapolis, Indiana; Monroe, Louisiana; Manchester, New Hampshire, and Toledo, Ohio have joined the national organization since the last printing of this Roll Call. Congratulations and best wishes are extended for success in all their endeavors.

FEDERATION EXECUTIVE BOARD MEETING
SCHEDULED

The Executive Board of the National Federation of Catholic Physicians' Guilds will hold its annual meeting June 10, 1959. Time: 9:30 a. m. Place: Hotel Dennis, Atlantic City, New Jersey.

The officers of the national organization and one delegate from each active constituent Guild comprising the Board will conduct business.

Election of officers.

Important Events . . .

Catholic physicians attending the A. M. A. convention in Atlantic City will have a busy day, June 10. The Federation is sponsoring the activities we enumerate here —

Executive Board Meeting

The Executive Board Meeting is scheduled for 9:30 a.m. at the Hotel Dennis. Early appointment of Guild delegates urged. Session will close at 1:00 p.m. Officers of the Federation will be elected at this meeting.

Memorial Mass

St. Nicholas Church, 5:00 p.m. . . . All Catholic physicians and their families are invited to assist at the Holy Sacrifice of the Mass for deceased members of the American Medical Association.

Reception

The Federation officers and Board members will be hosts at a reception from 6:00 until 7:30 p.m. at the Hotel Dennis. The invitation is extended to all Catholic physicians attending the A.M.A. convention and is not limited to Guild membership. Please indicate below your intention to attend and mail to the central office. This will assist the Catering Manager in preparing refreshments. You will be the guest of the Federation. Admission by ticket. Write for yours today.

Federation of Catholic Physicians' Guilds
Miss Jean Read, Asst. Secy.
1438 So. Grand Blvd.
St. Louis 4, Missouri

Please include me as a guest for the Federation of Catholic Physicians' Guilds reception, June 10, 1958, from 6:00 to 7:30 p.m. at the Hotel Dennis, Atlantic City, New Jersey.

Name

Address

City and State

